



August 26, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I am responding to the request for information (RFI) regarding various aspects of the Medicare Advantage (MA) program.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA members encounter challenges with MA plan coverage in a variety of practice settings including inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs), as well as outpatient settings such as private practices. As a result, ASHA members have a vested interest in ensuring the MA program is refined and strengthened over time to meet the needs of Medicare beneficiaries.

ASHA appreciates the comprehensive nature of this RFI to include health equity, expanding beneficiary access to care, innovation and value, affordability and sustainability, and engaging stakeholders. ASHA offers the following recommendations to assist CMS in improving MA for beneficiaries and the clinicians who serve them.

A. Advance Health Equity

ASHA shares CMS's continued commitment to health equity and health care disparities.

- 1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:**
 - **Enrollees from racial and ethnic minority groups.**
 - **Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.**
 - **Enrollees who identify as transgender, non-binary, or another gender identity.**
 - **Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.**
 - **Enrollees with diverse cultural or religious beliefs and practices.**
 - **Enrollees of disadvantaged socioeconomic status.**
 - **Enrollees with limited English proficiency or other communication needs.**

- **Enrollees who live in rural or other underserved communities.**

ASHA recommends several steps CMS could take in its MA oversight capacity to ensure MA enrollees receive the care they need, particularly to safeguard health equity.

First, CMS's network adequacy standards for MA plans consider the number of providers as well as time and distance to reach those providers. **ASHA recommends that CMS clarify that its network adequacy standards consider the total number of providers in network for a particular locality**, including representation of specialty types such as physician, audiologist, speech-language pathologist (SLP), or other clinical specialty. It is critical for there to be an adequate number of clinicians across clinical specialties, including subspecialties such as swallowing, cognition, voice, aural rehabilitation, hearing care (e.g., hearing aids, cochlear implants), balance disorders, and gender-affirming care, to ensure timely access to medically necessary care. A 2015 report by the Government Accountability Office (GAO) found that between 2013 and 2015, CMS reviewed less than 1% of MA plans for network adequacy.¹ Poor oversight of networks puts MA enrollees at risk for avoidable negative health outcomes and unnecessary functional decline that could be mitigated by timely access to care.

Second, time and distance are also critical to evaluate for patients with disabilities and those of disadvantaged socioeconomic status. Patients with disabilities often have trouble getting to appointments and require the assistance of a caregiver. Traveling a long distance to obtain care further compounds the challenges for patients with disabilities in gaining access to care. For patients and their accompanying caregivers who are socioeconomically disadvantaged, taking unpaid time off from work along with travel expenses can prove insurmountable challenges in accessing care. **ASHA recommends that network adequacy must consider the impact of time and distance across patient populations to ensure timely access to care.**

Third, many health plans operating in the MA marketplace also operate in other sectors of the private insurance industry, such as private health insurance plans offered through employers and the Exchange marketplace. It is ASHA's understanding that many of the policies private insurers adopt across multiple "lines of business" are not always specific to one sector of the market. Consequently, **ASHA recommends that CMS coordinate standards with requirements for plans on the private market including group health plans, Exchange plans, and MA plans.** For example, according to the calendar year 2023 Notice of Benefits and Payment Parameters (NBPP) final rule, CMS will evaluate qualified health plans (QHPs) for compliance with quantitative network adequacy standards based on time and distance standards. Beginning in plan year (PY) 2024, CMS will also evaluate QHPs for compliance with appointment wait time standards. These reviews will occur prospectively during the QHP certification process. Issuers that are unable to meet the specified standards would be able to submit a justification to explain why they are not meeting the standards, what they are doing to work towards meeting them, and how they are protecting consumers in the meantime.

Fourth, ASHA members report that they are often prevented from enrolling as in-network providers for many private health insurance plans, including MA plans. When these members contact the plan to engage in the credentialing process, they are told the panel is closed. However, plans rarely provide a rationale or explanation for why the panel is closed. ASHA has determined that, in many circumstances, private insurers keep narrow networks to control utilization and spending to the detriment of the plan's enrollees. If the enrollee cannot find an in-network provider, their out-of-pocket spending increases, which has a negative impact on socioeconomically disadvantaged enrollees. **ASHA recommends that CMS consider developing criteria with which MA plans must comply for closing panels for specific**

provider groups. For example, a plan might require the clinician to participate in a value-based purchasing arrangement or meet specific quality of care requirements. Outside of these criteria, any clinician applying to the network should be included to ensure access to care for MA plan enrollees. **ASHA further recommends that network adequacy consider wait times for appointments.** If MA enrollees are waiting substantial periods of time for appointments (e.g., longer than two weeks), ASHA recommends for CMS to require the MA plan to open its provider network to improve access to care for the plan's enrollees.

Fifth, **ASHA recommends that CMS review several factors associated with the adequacy of the benefit offered by MA plans.** A recent report by the Office of the Inspector General found that 13% of the MA plan denials it reviewed would have been covered if the MA enrollee had been covered under traditional Medicare.² While MA plans are required to cover benefits under Medicare Parts A and B, including care provided in inpatient rehabilitation or SNFs or outpatient services such as audiology assessment and speech-language pathology services, MA plans are allowed to use proprietary utilization management techniques to “refine” the benefit. This means that two clinically similar Medicare beneficiaries might not have access to the same care depending on whether they are enrolled in traditional Medicare or an MA plan. ASHA recommends that CMS provide greater oversight of plan restrictions that do not outright eliminate coverage for services, but serve often to limit MA enrollees from obtaining access to medically necessary services.

Finally, CMS requests feedback on how it can ensure that MA enrollees with limited English proficiency or other communication needs receive the health care they need. **ASHA recommends that CMS ensure MA plans comply with existing state and federal laws to protect MA enrollees with limited English proficiency or other communication needs.** Many states have laws requiring translation and interpretation services. Title VI of the Civil Rights Act of 1964 mandates equal access to services regardless of language used. Executive Order 13,166 further stipulates those agencies receiving public funding, such as Medicaid/Medicare or IDEA funding, must provide and arrange for those supports and are responsible for the funding of an interpreter, transliterator, or translator, as needed. The Americans with Disabilities Act of 1990 prohibits discrimination and ensures equal opportunity for persons with disabilities in the areas of employment, state and local government services, public accommodations, commercial facilities, and transportation. Congress has mandated the need for auxiliary aids and services—such as interpreters, transliterators, and translators—to ensure equal opportunity for individuals with disabilities (Americans with Disabilities Act of 1990). ASHA recommends CMS develop specific guidance that helps MA plans, their networks of clinicians, and the patients they serve understand their rights to access the services of interpreters, translators, and other associated services in an effort to maintain access to care and promote health equity.

ASHA also recommends that CMS review primary and supplemental benefits to ensure they meet its expectation for health equity. For example, MA plan coverage should be assessed for factors such as, but not limited to, mental health, voice, and hormonal therapy for transgender individuals.

2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

AIM Specialty Health (now Elevance) has expanded the use of its clinician portal across the country. This portal allows providers to easily navigate prior authorization guidance as well as

submit claim-related information for patients. ASHA members report that its usability and the inclusion of comprehensive information has resulted in fewer claims denials. Elevance guidelines also incorporated ASHA recommendations and resources into its final products and allow for updates as necessary. The inclusion of clinical information from specialty societies, such as ASHA, ensures that claim approvals or denials are based on clinical evidence, research, and standards of practice. ASHA continues to engage payers to help ensure patients maintain access to medically necessary care.

3. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

AmeriHealth Caritas has launched a new company called Social Determinants of Life, Inc. This initiative is one of the first of its kind offered by an insurance provider that addresses the health outcomes of people who are challenged by poverty and disability. Many insurance providers attempt to demonstrate they are taking the “total health” approach when it comes to social determinants of health, but most continue to operate in silos when it comes to explicitly targeting certain communities or demographics that may be at higher risk. For example, under the guise of addressing SDOH, these plans actually focus on narrow criteria such as obesity, heart health, or specific populations, such as African Americans, rather than a “whole person” approach. Expanding upon these innovations, such as those implemented by AmeriHealth Caritas, will be critical in the collective effort to address SDOH.

4. What have been the most successful methods for MA plans to ensure access to language services for enrollees in different health care settings? Where is improvement needed?

Given that many MA plan operators are operating in multiple private insurance marketplaces, ASHA maintains that it is appropriate to apply similar requirements across plan offerings, such as those standards applied to 1557 plans. For example, in the 2024 proposed rule, CMS would require compliance with specific standards to assist individuals with limited English proficiency (LEP) access care including a requirement that language access procedures must include:

- information detailing the contact information for the Section 1557 Coordinator (if applicable);
- how an employee identifies whether an individual is LEP;
- how an employee obtains the services of qualified interpreters and translators the covered entity uses to communicate with LEP individuals;
- the names of any qualified bilingual or multilingual staff members; and
- a list and the location of any electronic and written translated materials the covered entity has, the languages they are translated into, and the publication/review dates.

5. What socioeconomic data do MA plans leverage to better understand their enrollees and to inform care delivery? What are the sources of this data? What challenges exist in obtaining, leveraging, or sharing such data?

Obtaining data related to socioeconomic disadvantaged communities may be difficult for several reasons, including the abilities to access or utilize technology. Some health plans have

effectively partnered with community centers, shelters, and food banks to obtain information on how best to reach and help such technologically challenged populations as there is likely a correlation between those seeking such services and those needing extra assistance associated with their health-related needs.

- 10. How have MA plans and providers used algorithms to identify enrollees that need additional services or supports, such as care management or care coordination? Please describe prediction targets used by the algorithms to achieve this, such as expected future cost and/or utilization, whether such algorithms have been tested different kinds of differential treatments, impacts, or inequities, including racial bias, and if bias is identified, any steps taken to mitigate unjustified differential outcomes. For MA plans and providers that do test for differential outcomes in their algorithms, please provide information on how such tests function, how their validity is established, whether there is independent evaluation, and what kind of reporting is generated.**

ASHA finds that MA plans and private insurers often use algorithms and other predictive analytic tools or utilization management techniques to restrict access to care—such as placing limits on the number of therapy services that can be provided in one year or the clinical characteristics required for admission to an IRF—instead of expanding access to care. This is reinforced by findings of the OIG report, noted above, that highlight that services denied by MA plans would often be covered under traditional Medicare.³

B. Expand Access: Coverage and Care

- 1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?**

First, ASHA recommends that CMS ensure MA plan documents are in language easily understood by beneficiaries. Second, ASHA recommends that CMS consider requiring MA plans to develop side-by-side comparisons of coverage to help facilitate a prospective enrollee's plan selection process. Such comparisons have been effectively developed for Exchange plans. Finally, ASHA recommends that CMS determine how it may most effectively raise awareness for the State Health Insurance Assistance Program (SHIP) to help beneficiaries determine the best Medicare product for their needs.

- 2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?**

Education is key. MA products are marketed to many beneficiaries who are not health care savvy and need additional assistance in determining if a particular plan meets their specific health care needs. Educating beneficiaries and providing resources so they are fully aware of what they are signing up for is key to the success of these programs. Several educational items important for this purpose include cost sharing information, visit limitations, and prior authorization requirements. ASHA recommends that CMS leverage its authority under the No Surprises Act (PL 116-260) to ensure MA plan enrollees are both not caught off guard by out-of-pocket costs and coverage limitations, and aware of appeals procedures once enrolled in a specific plan.

Widespread confusion exists within both the clinician and beneficiary community regarding the difference between a supplemental plan for traditional Medicare and a replacement plan under MA. These concepts are often used interchangeably despite major differences in products and intended markets between the terms. ASHA recommends that CMS develop additional resources to define the distinctions between supplemental plans and MA plans more clearly.

3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

ASHA reiterates many of its recommendations above, including the development of resources in plain language, tools that help enrollees compare consumer options, and the use of newly created enforcement mechanisms like the No Surprises Act.

5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS's statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

According to a report issued by the Better Medicare Alliance, 95% of MA plans provide some form of a telehealth benefit. Audiologists and SLPs are trained and qualified to provide services via telehealth.⁴ Telehealth services often help reduce the transmission of disease such as COVID-19, improve timely access to care for patients, and reduce costs (e.g., transportation, time off from work) for patients. Some patients also have a personal preference for telehealth services. ASHA supports access to telehealth services when appropriate based on the patient's clinical presentation.

Research demonstrates the equivalence of telehealth to in-person service delivery for a wide range of diagnostic and treatment procedures for adults and children.⁵ Studies have shown high levels of patient, clinician, and parent satisfaction supporting telehealth as an effective alternative to the in-person model for delivery of care.⁶ Despite proven benefits, telehealth remains underutilized within audiology and speech-language pathology due to inconsistent adoption by payers (e.g., Medicare, Medicaid, private insurance).

ASHA acknowledges that CMS must also work to address telehealth payment considerations and support telehealth coverage at parity with in-person services to encourage robust telehealth offerings for MA plans. Twenty-nine states and the District of Columbia have passed telehealth parity laws. However, in the remaining states without telehealth parity laws, insurers are beginning to reduce reimbursement rates to providers who are offering telehealth services. Providers have many fixed costs regardless of the manner of service delivery, which include labor, HIPAA compliant software, and hardware needed for telehealth delivery. In addition, overhead costs are not significantly reduced when health care practitioners provide a small subset of their overall services via telehealth. A journal article by Snoswell, Taylor, Comans, Smith, Gray, & Caffery (2020) concludes, "Health services considering implementing telehealth should be motivated by benefits other than cost reduction. The available evidence indicates that although telehealth provides overwhelmingly positive patient benefits and increases productivity for many services, current evidence suggests that it does not routinely reduce the cost of care delivery for the health system."⁷ There are many benefits to telehealth for insurers and

beneficiaries alike but reducing payment to telehealth providers undercuts those benefits and risks ongoing access.

6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

As noted above, ASHA remains concerned that changes to networks are made with utilization and profit as the top priorities rather than beneficiary access and health care needs. It is critical for CMS to remain committed to robust network adequacy verification and enforcement. ASHA recommends a variety of adequacy monitoring and enforcement techniques including time and distance standards, network adequacy across clinical specialties and subspecialties, and review of appointment wait times.

7. What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS's MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits?

Like all private insurance plans, MA plans conduct a cost/benefit analysis to determine when supplemental benefits would lower overall costs—such as preventive benefits that might prevent high-cost emergency room visits or hospitalizations—and what benefits that would increase their costs such as dental or vision benefits. Insurers then determine how they can structure premiums in a way to demonstrate value to plan enrollees and ensure they are competitive in the insurance marketplace and return value for their shareholders. In some instances, supplemental benefits might not be offered if the plan cannot demonstrate the value of the benefit or make a return on investment. In others, the low cost of supplemental benefits and the high rate of return by avoiding more expensive care along with the value proposition allow plans to offer such benefits.

10. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

According to an OIG report issued in April 2022, MA plan utilization of prior authorization is widespread and highly problematic.⁸ For example, 18% of prior authorization denials issued by MA plans reviewed met the MA plan's coverage and billing rules and the denials were often the result of human error. Many of these initial denials were overturned on appeal leading to delays or disruptions in accessing medically necessary care and increasing the risk and frequency of preventable negative health outcomes for the patient.⁹ The problem is so significant that the trade organization representing MA plans has endorsed legislation introduced to address the problem. Supported by ASHA, The Improving Seniors' Timely Access to Care Act (H.R. 3173/S. 3018) would curtail these inappropriate utilization management techniques to help ensure that MA plan enrollees receive access to timely, medically necessary care.

In its report, the OIG made several recommendations to CMS to mitigate the problems created by utilization management techniques such as prior authorization. For example, the OIG recommended that CMS should issue new guidance on both the appropriate use and the inappropriate use of MA clinical criteria that are not contained in Medicare coverage rules. The guidance should clarify what the Medicare Managed Care Manual means when it says that MA clinical criteria must not be “more restrictive” than Medicare coverage rules, and it should include specific examples of criteria that would be considered allowable and unallowable.

In addition, the OIG recommended that CMS should update its audit protocols to look for issues identified in this report. Although CMS’s audit protocols already direct auditors to review a sample of denial cases to determine whether the denials were issued appropriately, the OIG suggested that CMS should add additional prompts for auditors. For example, if CMS developed new guidance relating to the use of clinical criteria in medical necessity reviews, CMS could add questions for auditors in section 3.2 of its audit protocol (Clinical Appropriateness of Denials) to determine whether MA plans are following the new guidance. CMS could also add a question for auditors examining whether MA plans requested unnecessary documentation. If MA plans are found to be noncompliant because they use more restrictive clinical criteria or request unnecessary documentation, CMS should follow its normal enforcement action process, including adding aggravating factors in civil money penalty calculations if MA denials resulted in beneficiaries’ not being able to access needed services. Furthermore, OIG recommended that CMS consider additional enforcement actions for MAOs that demonstrate a pattern of inappropriate payment denials.

Finally, the OIG suggested that while some of the denials discussed in its report were attributable to occasional human error, others seemed preventable through process or system changes by MA plans. Therefore, it was recommended that CMS should direct MA plans to examine their processes for manual review and system programming and remediate vulnerabilities that may result in inappropriate denials. Included in Appendix B of the OIG report were detailed explanations of the types of errors MA plans could use to identify the types of errors that they should be looking for. To help avoid system errors, CMS could direct MA plans to take additional steps to ensure that any changes affecting coverage or payment, especially those on an established schedule (e.g., renewal of a provider’s contract with the MA plan), are properly coded in their systems. CMS could also direct MA plans to consider additional staff training on documentation that should be verified before issuing a denial, and the level of documentation required.

It is to be expected that user error would result in both inappropriate coverage as well as denials of care. If CMS identifies trends toward care denials, ASHA recommends that CMS carefully monitor the payment incentive system used by health plans to review authorizations and claims to ensure that there isn’t a systematic cause for the denial trends.

C. Drive Innovation to Promote Person-Centered Care

- 1. What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?**

A variety of factors influence an MA plan's determination to establish a value-based contracting arrangement including the startup cost for the arrangement and the administrative burden and cost of transitioning from a volume to value-based system. Many plans have found that focusing on the upside risk or rewards is more likely to secure clinician and patient engagement as opposed to the downside risk or financial penalties.

Moving forward, ASHA recommends the establishment of common quality metrics across MA and traditional Medicare. These metrics would be tremendously helpful to understand what, if any, differences exist in the quality of care between MA and traditional Medicare beneficiaries.

- 5. Do certain value-based arrangements serve as a “starting point” for MA plans to negotiate new value-based contracts with providers? If so, what are the features of these arrangements (that is, the quality measures used, data exchange and use, allocation of risk, payment structure, and risk adjustment methodology) and why do MA plans choose these features? How is success measured in terms of quality of care, equity, or reduced cost?**

Plans with only upside risk that offer significant financial benefit, provide funding for start-up costs, pull data directly from existing electronic health records (EHRs), and allow the clinical flexibility to do what is best for the patient (including addressing SDOH) would help entice providers towards value-based models.¹⁰

- 8. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?**

ASHA notes that the Medicare Payment Advisory Commission (MedPAC) has long-standing concerns regarding the MA Star Ratings System. In its March 2021 report, MedPAC stated:

“The current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care in MA. With 43 percent of eligible Medicare beneficiaries enrolled in MA plans, good information on the quality of care MA enrollees receive and how that quality compares with quality in FFS Medicare is necessary for proper evaluation. The ability to compare MA and FFS quality and to compare quality among MA plans is also important for beneficiaries. Recognizing that the current quality program is not achieving its intended purposes and is costly to Medicare, in its June 2020 report the Commission recommended a new value incentive program for MA that would replace the current quality bonus program.”¹¹

ASHA recommends CMS consider MedPAC's suggestions and determine what improvements could be made to the MA Star Ratings system.

- 11. What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBID Model? What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits?**

ASHA recommends that CMS ensures speech-language pathology services are included in hospice benefits just as they are included in traditional Medicare. These services address symptom control and maintenance of activities of daily living (ADLs) as well as basic functional skills such as eating, drinking, swallowing, along with maintaining the patient's communication to express care needs.

D. Support Affordability and Sustainability

2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

Accurate risk adjustment that considers SDOH and not just clinical presentation of the patient could eliminate incentives to exclude populations or "cherry pick" patients.

3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

ASHA recommends that CMS consider if it should require MA plans to cover benefits in the same way as traditional Medicare. As noted above, MA plans use of prior authorization has uncovered trends that indicate that MA plan enrollees do not have the same access to coverage as traditional Medicare beneficiaries.¹² While some may argue that supplemental offerings counter differences in coverage, Medicare beneficiaries have come to expect that they will receive a standard benefit whether offered through traditional Medicare or an MA plan. Any allowable variations must be clearly indicated and explained to beneficiaries before choosing such plans.

E. Engage Partners

2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?

ASHA remains committed to partnering with all stakeholders to demonstrate the value of the services audiologists and speech-language pathologists provide to patients. Providing an opportunity to comment on coverage or payment changes would be a tremendous opportunity to engage stakeholders.

ASHA strives to be at the forefront of innovative care for audiology and speech-language pathology services. ASHA welcomes the opportunity for collaboration between clinicians and payers to develop coverage policies that reflect clinical standards of practice, evidence, and research. To increase collaboration, ASHA hosts an annual payer summit, which brings together key members of the payer community to discuss the role of ASHA members in treating communication disorders to develop robust coverage policies. The summit also serves as a forum to identify compliance issues and opportunities for ASHA to help resolve these issues through member education.

3. What steps could CMS take to enhance the voice of MA enrollees to inform policy development?

ASHA recommends that CMS establish a public comment period for the development of new MA coverage policies or changes to existing coverage policies. The process could be similar to that used by Medicare Administrative Contractors (MACs) in the development or update of local coverage determinations (LCDs). It seems reasonable that all coverage policies should be informed by the experiences and knowledge of its beneficiaries and clinicians to ensure appropriate development of these policies.

Thank you for the opportunity to comment in response to this RFI. If you or your staff have any questions, please contact Sarah Warren, MA, ASHA's director for health care policy, Medicare, at swarren@asha.org.

Sincerely,



Judy Rich, EdD, CCC-SLP, BCS-CL
2022 ASHA President

¹ Government Accountability Office. (August 31, 2015). Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy.

² U.S. Department of Health and Human Services Office of the Inspector General. (April 27, 2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care.

³ U.S. Department of Health and Human Services Office of the Inspector General. (April 27, 2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care.

⁴ State of Medicare Advantage. (July 2022). Better Medicare Alliance. <https://bettermedicarealliance.org/news/better-medicare-alliance-unveils-2022-state-of-medicare-advantage-report/>.

⁵ Grogan-Johnson, S., Alvares, R., Rowan, L., & Craghead, N. (2010). A pilot study comparing the effectiveness of speech language therapy provided by telemedicine with conventional on-site therapy. *Journal of Telemedicine and Telecare*, 16, 134–139.

⁶ Ibid.

⁷ National Library of Medicine. (2020). Determining if Telehealth Can Reduce Health System Costs: Scoping Review. <https://pubmed.ncbi.nlm.nih.gov/33074157/>.

⁸ U.S. Department of Health and Human Services Office of the Inspector General. (April 27, 2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care.

⁹ Ibid.

¹⁰ Mechanic, R., Perloff, J., Litton, T., Edwards, K., Muhlestein, D. The 2018 Annual ACO Survey: Examining the Risk Contracting Landscape. *Health Affairs*. April 23, 2019.

<https://www.healthaffairs.org/doi/10.1377/forefront.20190422.181228/full/>

¹¹ Medicare Payment Advisory Commission (MedPAC). March 2021 Report, Chapter 12. The Medicare Advantage program: Status report.

¹² U.S. Department of Health and Human Services Office of the Inspector General. (April 27, 2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care.