ASHA
American
Speech-Language-Hearing
Association

January 27, 2025

Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
U.S Department of Health and Human Services
Attention: CMS-4208-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Administrator Wu:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write in response to the Medicare Advantage (MA) proposed rule for contract year 2026.

ASHA is the national professional, scientific, and credentialing association for 234,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Audiologists and SLPs provide vital services to patients in a variety of health care settings that bill for services under the fee schedule and have a vested interest in ensuring that the payment system reflects the value of audiology and speech-language pathology services and supports access to care for Medicare beneficiaries.[1]

Overall, ASHA greatly appreciates the work the Centers for Medicare & Medicaid Services (CMS) has done to ensure MA plans are providing comparable coverage to Medicare beneficiaries as those provided through traditional Medicare. CMS' work to ensure utilization management techniques used by MA plans do not inappropriately deny or delay access to care for patients is critical, particularly in light of recent findings by the Senate Permanent Committee on Investigations, which released a report in October 2024 outlining how these techniques harm Medicare beneficiaries.[2]

ASHA supports several of the provisions of this proposed rule that we believe reinforce and enhance work done to date to ensure transparency and accountability for MA plans. We urge CMS to finalize these provisions.

Updates to the Requirements for Provider Directory Data

CMS proposes several updates to the requirements associated with provider directory data, including to

- Use this data to populate the Medicare Plan Finder; and
- Require MA organizations to attest that this information is accurate and consistent with data submitted to comply with CMS' MA network adequacy requirements.

ASHA agrees with CMS that, at a minimum, this will help with transparency so that patients can effectively and efficiently identify a plan's provider network and make informed choices regarding whether to enroll with a particular plan. Ideally, it will also encourage MA plans to

ensure this information is accurate, comprehensive, and up to date. We encourage CMS to finalize this proposal.

An accurate and comprehensive Medicare Plan Finder will help clarify which providers are enrolled in an MA network, and ASHA is concerned it may demonstrate how insufficient these networks truly are. One cause of a deficient provider network could be the complexity of the credentialing process for providers**.** As a result, **ASHA recommends CMS add provisions to simplify provider enrollment in and contracts with MA plans to improve patient access to in-network providers, support continuity of care, and reduce out-of-pocket costs.**

We often receive complaints from providers and beneficiaries that challenges with credentialing and contracting with MA organizations are affecting patient access to care. Credentialing and contracting requirements established by MA plans can be very different for each plan—even when working with Council for Affordable Quality Healthcare (CAQH), the entity which helps facilitate the credentialing process for providers. Providers indicate that it is difficult to navigate all the MA organizations' enrollment processes, obtain copies of their enrollment contracts, and determine whether they are enrolling with the commercial plans, MA plans, or both. All of this reduces the incentive for providers to enroll with MA plans and continue working with beneficiaries enrolled in MA plans.

Provider enrollment with MA organizations should be simplified and offer clear indication of the plans in which they are enrolling. Providers should also be able to easily obtain copies of their contracts with MA organizations to verify their enrollment and terms.

Updated Requirements for MA Plan Agents and Brokers

CMS also proposes to update requirements for the topics MA plan agents and brokers must discuss with prospective enrollees to include:

- The availability of low-income supports, including the Part D Low-Income Subsidy (also known as "Extra Help") and Medicare Savings Programs;
- Requiring that agents pause to address remaining questions the beneficiary may have related to enrollment in a plan prior to moving forward with an enrollment;
- For beneficiaries enrolling in MA when first eligible for Medicare or dropping a Medigap plan to enroll in an MA plan for the first time
    - General information on Medigap federal guaranteed issue (GI) rights;
    - The practical implications of switching from MA to traditional Medicare; and
    - When applicable, provide information on state laws regarding Medigap GI rights for those states where the agent or broker is licensed and appointed to sell.

ASHA agrees that ensuring MA plan agents and brokers include all the information necessary for beneficiaries to make informed and appropriate choices regarding their health care coverage, including having their questions answered, are important beneficiary protections that should be finalized.

Compliance With 42CFR 422.111

In the proposed rule, CMS reiterates existing regulatory requirements applicable to MA plans, including that MA organizations disclose all benefits offered under an MA plan—including applicable conditions and limitations and any other conditions associated with receipt or use of benefits in the plan's evidence of coverage provided to plan beneficiaries.

ASHA remains concerned that when an MA plan makes changes to its evidence of coverage—such as requiring prior authorization for audiology or speech-language pathology services—during the contract year, this evidence of coverage is not updated appropriately and creates a "bait and switch" system that harms Medicare beneficiaries who choose MA plans.

For example, if an insurance company offering an MA plan (or plans) decides to require prior authorization, limit the number of visits allowed, or impose a financial limitation on a type of clinical service at some point after open enrollment during the contract year, the benefit the patient expected to receive is no longer covered or is covered in a different, potentially detrimental way. Further, the insurance company may send the beneficiary documentation highlighting the change, but the documentation is often worded in confusing ways the beneficiary may not understand. This confusion leads to frustration, and the beneficiary often relies on the clinician to help them navigate this change, placing an untenable additional administrative burden on the clinician.

ASHA believes a single notification via email or mail delivery is insufficient, particularly when only 30 days' notice is given, which is often the case. If coverage changes in ways that restrict or eliminate access to a service the beneficiary expected to receive when they enrolled in the plan, the beneficiary has no recourse until the next open enrollment period.

Changes made mid-year also impact the contracts clinicians sign with MA plan sponsors. Clinicians who signed a contract that did not include prior authorization requirements or visit/financial limitations are now faced with challenging decisions regarding their ability to remain in-network with a payer. If the contract terms jeopardize the clinician's or practice's ability to remain financially viable, they may exit the network, which further limits Medicare beneficiaries' access to care.

ASHA has raised these concerns in meetings with CMS associated with specific MA plan sponsors, and we remain committed to ensuring that changes to the terms of a clinician's contract or a beneficiary's coverage are made in ways that maintain access to coverage. **We ask CMS to regulate when and/or how an MA plan makes changes to its policies.** This could be through one of two methods:

1. Allow MA plans to make changes to their coverage and utilization management policies at any time if they publish the change publicly and offer a comment period for stakeholder input prior to implementation. This would give beneficiaries and providers a chance to respond and time to adjust to upcoming changes.
2. Restrict MA plans from making changes mid-year and require that they announce changes during the open enrollment period to begin in the next calendar year. This would allow providers and beneficiaries the ability to select a plan they know will meet their needs throughout the next year.

Compliance With 42 CFR 422. 101(b)(6)(i)

As explained in this proposed rule, CMS finalized requirements associated with the development of internal coverage criteria by MA plans under specific circumstances. One element of these new regulatory requirements was that the plan must demonstrate that the additional criteria the MA organizations apply provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services. While ASHA agrees this requirement is a step in the right direction, in practice it may not have had the impact CMS intended. Specifically, in MA policy and coverage documents we have reviewed that were issued since this requirement was implemented, plans simply stated that the coverage choices they have made using internal coverage criteria have a clinical benefit, and

these choices outweigh clinical harm. However, they do not state *how* these coverage choices do this. This indicates that plans are meeting the letter, but not the spirit, of the regulatory requirements.

These plans also state in their coverage documentation that they are supplementing existing Medicare coverage requirements outlined in local and national coverage determinations (LCDs and NCDs, respectively) but do not specifically tie the internal coverage criteria to the LCDs and NCDs or other regulatory guidance. As a result, ASHA is pleased to see CMS propose methods to strengthen these regulatory requirements to require plans to "connect the dots" in "plain language" to ensure transparency and compliance.

We encourage CMS to adopt its proposed change to require MA organizations to demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms with the added requirement to establish evidence that the additional criteria explicitly support patient safety. ASHA agrees it is important to further define terms to prevent MA organizations from using guidance to justify inappropriate policies that create barriers to care rather than barriers to harm. Even with additional clarification of terms, ASHA is concerned that MA organizations will continue to develop internal coverage criteria that limits or challenges access to medically necessary care.

CMS also proposes to require that by January 1, 2026, MA organizations must publicly display on the MA organization's website a list of all items and services for which there are benefits available under Part A or Part B and where the MA organization uses internal coverage criteria when making medical necessity decisions. **ASHA supports this proposal but encourages CMS to strengthen it by requiring all relevant policy documentation to be "packaged" and accessible without additional burden, such as having to register for an account or look in multiple places.** For example, one MA plan sponsor has developed prior authorization requirements for therapy services based on internal coverage criteria. Unfortunately, the guidance is currently scattered across three separate documents in different locations and can only be accessed after creating an account. This documentation should be maintained together in one location and easily accessible to all stakeholders, including patients and clinicians.

Finally, we want to reiterate our recommendation that CMS require MA plan coverage policies be subject to a notice and comment period as is required for LCDs and NCDs. This will allow stakeholders to review the evidence and research that MA plan coverage policies purport to be based upon and ensure clinically appropriate care is covered. Without such a requirement, there is no appropriate communication channel between stakeholders and the MA plans.

Improving Experiences for Dually Eligible Enrollees

In the proposed rule, CMS suggests several changes to align and simplify the experience of patients who might be covered under both an MA plan and a Medicaid managed care organization (MCO), including:

- Having integrated member identification (ID) cards that serve as the ID cards for both the Medicare and Medicaid plans in which a beneficiary is enrolled;
- Conducting an integrated health risk assessment (HRA) for Medicare and Medicaid, rather than separate HRAs for each program; and
- Codifying timeframes for special needs plans to conduct HRAs and individualized care plans (ICPs) and prioritize the involvement of the enrollee or the enrollee's representative, as applicable, in the development of the ICPs.

Over 8 million individuals are full-benefit dually eligible for Medicare and Medicaid. The changes proposed in the rule would help better address health coverage for these individuals who are often among the most medically complex and costly. Increased enrollee involvement as proposed would only serve to better ensure integrated care. Therefore, ASHA requests that CMS finalizes these proposals.

Permitted Primarily Health-Related OTC Items That Have Been Approved by CMS

In the proposed rule, CMS solicits feedback on what additional over-the-counter (OTC) items should be approved by CMS as permitted because they are primarily health-related. It provides a nonexhaustive list of the types of items it has approved to date. Audiologists and SLPs recommend a variety of OTC items to their patients to help facilitate the goals of treatment. Therefore, ASHA offers the following items for future consideration as CMS vets these proposals from MA plans.

Audiology-Related Primarily Health-Related OTC Items

- Personal sound amplifiers
- Hearing aid/cochlear implant desiccant kits
- Hearing aid care kits (cleaning tools)
- Hearing aid wax filters
- Hearing aid domes
- Alerting devices (shake awake, light flashers, etc.)
- Ear wax removal products (e.g., Debrox)
- OTC swim plugs
- OTC hearing protection

Speech-Language Pathology-Related Primarily Health-Related OTC Items

- Communication supports, such as tablet computers, text-to-speech products, word prediction software, screen readers, adaptive communication switches
- Tube feeding equipment
- Dietary thickeners, pre-thickened liquids
- Inhalatory and exhalatory training tools
- Jaw splints

Guardrails for Artificial Intelligence (§ 422.112)

CMS proposes to require MA organizations to ensure services are provided equitably irrespective of whether artificial intelligence (AI) or automated systems are used. Furthermore, AI or automated systems, if utilized to make coverage determinations, must be used in a manner that preserves equitable access to MA services. Finally, MA organizations must provide enrollees with equitable access to services under the MA plan design or benefits or both regardless of the tools or methods utilized to make care decisions or to provide that care.

ASHA supports the proposed change, which codifies the principles of health equity and protection against bias in the face of new and emerging AI technology in health care. The bias inherent in historical medical data for minoritized and underserved populations must be acknowledged and adjusted for when using said data to train tools that predict, guide, and fund

current medical diagnoses and treatment. Algorithmic discrimination could exacerbate existing inequities in the health care system by carrying forward historic underutilization and bias caused by false assumptions and unequal access to care.

ASHA recommends that CMS require MA plans to report if they use algorithms or AI in payment or prior authorization determinations. In addition, if a plan's utilization management committee has approved the use of AI in utilization management, a "human in the loop" should be required for any and all adverse determinations. A clinician, such as an audiologist or SLP, who has the clinical expertise related to the service in question should review and uphold or reject an adverse determination made via AI.

Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137)

CMS proposes to revise the required metrics for the annual health equity analysis of the use of prior authorization to require the following:

- The percentage of standard prior authorization requests that were approved, reported by each covered item and service
- The percentage of standard prior authorization requests that were denied, reported by each covered item and service
- The percentage of standard prior authorization requests that were approved after appeal, reported by each covered item and service
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, reported by each covered item and service
- The percentage of expedited prior authorization requests that were approved, reported by each covered item and service
- The percentage of expedited prior authorization requests that were denied, reported by each covered item and service
- The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, reported by each covered item and service
- The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, reported by each covered item and service.

ASHA supports the proposed disaggregation of health equity data. Due to the complexity of the health care system and the interprofessional and collaborative nature of high-quality patient-centered care, it is essential that health equity data be analyzed for all services regardless of provider type (including nonphysician qualified health providers). As noted above, the failure to account for health equity factors leads to inaccurate or false assumptions about the prevalence of conditions and the types of individuals who acquire these conditions. These assumptions can have long-term consequences that drive care decisions that may cause harm to patients or jeopardize access to care.

This disaggregation would help address ASHA's longstanding concerns that prior authorization disproportionately discriminates against individuals with chronic conditions and disabilities in need of habilitation and rehabilitation services. Heavy-handed prior authorization and reauthorization practices raise serious concerns under Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the Affordable Care Act. Section 504 prohibits discrimination in medical treatment decisions by health programs or activities that receive federal financial

assistance. Section 1557 prohibits discrimination based on race, color, national origin, sex, age, or disability in health programs or activities that receive federal financial assistance. The regulation further states that "this includes the designing of benefits in a manner that discriminates based on an individual's expected length of life, present or predicted disability, degree of medical dependency, or other health conditions."[3]

This is of particular concern for audiology and speech-language pathology services. In utilization management policies ASHA has reviewed, the types of limitations applied are not evidence-based, including visit or financial limitations or limitations associated with specific clinical conditions. Rather, as demonstrated by the Senate Permanent Subcommittee on Investigations, limitations are often imposed by health plans to save money regardless of medical necessity.[4]

Further, prior authorization is often used to limit patients to a certain number of visits per episode of care, and based on ASHA's review of coverage policies, it appears these decisions are largely based on the typical orthopedic patient, who does not represent the needs of a patient requiring speech therapy, for example. For instance, a routine orthopedic procedure, such as a knee replacement, has a largely predictable and duration-limited course of rehabilitation. But individuals with any significant injury, illness, disability, or chronic condition, such as brain injury, spinal cord injury, multiple traumas, neurological conditions, and other significant disabilities find these limits completely inadequate to meet their medically necessary needs. Prior authorization is nearly universal in private insurance and systematically underserves enrollees, requiring individuals in need to endure an exhausting appeals process, pay out of pocket, or go without—resigning themselves to accept a less functional life and lifestyle for themselves or their loved ones.

ASHA urges CMS to also consider gathering data on prior authorization requests for continued services, sometimes called reauthorizations, which greatly impacts individuals with disabilities and complex medical needs. It is not only challenging for patients to obtain initial authorization for services but can also prove more difficult to ensure continued coverage of medically necessary services due to burdensome reauthorization requirements. Most MA organizations will only authorize a small number of visits at a time, requiring additional authorizations for continued care.

For example, one MA plan has publicly stated it will authorize six initial visits over an eight-week period and require clinical review for any visits beyond this amount. Individuals with disabilities or complex medical needs often need two to three therapy visits per week over longer periods of time. This causes a significant burden for individuals with complex medical needs who must continually reapply for authorization. They often need to provide additional clinical documentation and reasoning to justify continued care. It is unfair and potentially discriminatory to require these individuals to complete so much more paperwork than others to obtain approval for their full plan of care.

Thank you in advance for your consideration of our comments. If you have additional questions, please contact Sarah Warren, MA, ASHA's director for health care policy for Medicare, at swarren@asha.org.

Sincerely,

A. B. Mayfield-Clarke, PhD, CCC-SLP

2025 ASHA President

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[1] U.S. Senate Permanent Subcommittee on Investigations. (2024, October 17). *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care*. 2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf
[2] Ibid
[3] 45 C.F.R. § 92.207
[4] Ibid