



May 20, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4207-NC,
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Request for Information Regarding Medicare Advantage Data

Dear Administrator Brooks-LaSure,

On behalf of the American Speech-Language-Hearing Association (ASHA), I am writing to offer comments in response to the request for information (RFI) on Medicare Advantage (MA) data.

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 important speech, language, hearing, and communication evaluation and treatment services to Medicare and MA beneficiaries in a variety of practice settings—including hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health, and private practices. In many instances, they have been harmed by the utilization management practices of MA plans. We have articulated these concerns to the Centers for Medicare & Medicaid Services (CMS) in previous comments.

ASHA appreciates CMS' efforts to provide additional guidance to and oversight of MA plans to ensure beneficiary access to care. We also welcome the opportunity to provide additional feedback on how MA utilization management techniques impact our members and the patients they treat in the interest of protecting their access to care. Please see our responses to specific questions outlined in the RFI below.

A. Data-related recommendations related to beneficiary access to care, including provider directories and networks

ASHA members consistently report extreme difficulty with gaining access to MA networks despite a willingness to contract with these plans. They are often told the network is closed. In addition, beneficiary advocacy organizations and our members report that the existing network directories are often inaccurate or incomplete. For example, a clinician is listed as in-network but when the beneficiary calls to schedule an appointment, they are told the clinician is no longer in-network or accepting patients covered by the MA plan. In other cases, the contact information for the clinician is inaccurate, such as a wrong phone number or address. The compounding effect of closed network and beneficiary challenges in accessing care makes it imperative that CMS encourage MA plans to offer broad networks to ensure beneficiary access to care. MA plans that are found to routinely have outdated or inaccurate information regarding

their network should face consequences for creating barriers to efficient access to care for their beneficiaries.

With regard to the specific data elements that would be helpful for MA plans to report to CMS and make publicly available, **ASHA recommends that network data include the number of clinicians by specialty, not just total clinicians in the network.** This will allow stakeholders to ensure there is sufficient capacity across clinical specialties. It is critically important that the data is as specific as possible. For example, SLPs, physical therapists, and occupational therapists should each be listed separately and not as part of a broad “rehabilitation” category.

In addition, CMS should maintain data that shows that the network allows for access to care across the state. For example, we often hear in large, predominantly rural states that the network is concentrated in cities, forcing MA beneficiaries to travel long distances for appointments.

B. Prior authorization and utilization management, including denials of care and beneficiary experience with appeals processes as well as use and reliance on algorithms

1. Prior authorization

ASHA appreciates rules issued in 2023 and 2024 to provide clear guidance to ensure prior authorization is not used to inappropriately deny access to medically necessary care for MA beneficiaries.^{1,2} We often hear from our members and MA beneficiaries that while a plan would cover a particular benefit or service—such as skilled nursing facility stays—the coverage criteria differed from traditional Medicare. As has been publicly reported, there is enough room for interpretation in coverage policies to allow MA plans to create mechanisms that unfairly limit access to care. For example, they use this to require arduous prior authorization processes and deny services that would have been covered by traditional Medicare fee-for-service plans.^{3,4} Clearly, it is not the intent of Congress or the Medicare program that a beneficiary’s access to care vary based on whether they are enrolled in traditional Medicare or an MA plan. ASHA is engaging with our membership to ensure that the requirements CMS has put in place over the last year are complied with. And we will bring problematic examples to CMS as they come to our attention.

One example that we are starting to hear about is MA plans using terms other than “prior authorization” in an effort to skirt the requirements of these final rules. Under prior authorization, the services were approved or denied prior to the initiation of care so the financial risk was minimal for the clinician or facility (though prior authorization did unnecessarily and inappropriately deny care for patients). Now that prior authorization techniques have been largely curtailed, ASHA members report that they are subject to pre-payment review. In this scenario, the clinician has provided the service—assuming potentially significant financial risk by doing so—and must submit the claim and medical record prior to being paid. What makes this especially egregious is that, in some circumstances, this must happen for each date of service. Speech-language pathology services are often provided multiple times a week over the course of a month or more, depending on the clinical presentation of the patient. Having to submit documentation for each claim across the episode of care creates a significant administrative burden for clinicians. **ASHA strongly urges CMS to**

investigate this issue to determine if there has been a shift to pre-payment review on the part of MA plans.

2. *Artificial intelligence as a utilization management tool*

ASHA has become aware of the increased use of artificial intelligence (AI) by private payers, including MA plans, to make payment decisions. ASHA remains concerned about the use of this technology, but it is premature to fully ban its use without additional experience. For example, there is inherent bias in AI as a utilization management technique because historical data has not captured information for all types of patients equally (e.g., people of color, women, people who identify as LGBTQ+, individuals with disabilities). This creates an underlying flaw in the AI algorithm. CMS should require MA plans to report if they use AI in payment or prior authorization determinations. Additionally, if a plan's utilization management committee has approved the use of AI in utilization management, the AI alone should not be the deciding factor for adverse decisions. 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.

3. *Public reporting of MA prior authorization statistics (denials per request, reason for denials, etc.)*

ASHA strongly supports the collection and public reporting of data associated with the beneficiary experience with prior authorization. For example, it is important to have data on the overturn rate on appeal in favor of the beneficiary and grievance process metrics—including, but not limited to, how many grievance claims have been brought by MA beneficiaries against a plan, average length of time to resolve the grievance, and the outcome.

We also support the collection and public reporting of all aspects of MA marketing practices—including, but not limited to, how much money an MA plan spends on marketing materials such as mailings and television or radio commercials.

Finally, ASHA supports the collection and public reporting of quality-of-care metrics—including any structure, process, or outcomes data, as well as risk adjustment factors such as health-related social needs. This will allow an accurate comparison of risk-adjusted quality of care being provided by traditional Medicare vs. MA plans.

Finally, plans should report on all aspects of value-based care arrangements, including the clinical conditions covered under such arrangements, the members of the multidisciplinary care teams incorporated into the arrangements, the quality of care, and the outcomes of patients attributed to these models.

C. Healthy competition in the market, including the impact of mergers and acquisitions, high levels of enrollment concentration, and the effects of vertical integration

We remain concerned that lack of competition in the marketplace has a disproportionate negative impact on clinicians and beneficiaries. For example, it creates situations where clinicians cannot effectively negotiate contracts to ensure the viability of their practices. ASHA members and many other providers report MA plans reimbursing at rates lower than traditional fee-for-service Medicare.⁵ Even large health care systems with strong negotiating power cite “inappropriate payment of claims and unreasonable denials.” This

demonstrates how challenging rate negotiations and claims management is for smaller practices.⁶ It also prevents beneficiaries from accessing benefits that meet their specific clinical needs and might increase their cost-sharing obligations such as premiums, deductibles, and co-payments. We are also concerned about the impact on beneficiary cost-sharing when there are high levels of enrollment concentration, particularly of clinically complex patients. **ASHA encourages CMS to closely monitor the MA marketplace to ensure fair and equitable access for clinicians and patients alike.**

D. Data format, fields, and content that would facilitate comprehensive analyses of any publicly released MA data

According to a 2023 report from the Better Medicare Alliance, MA plans serve a more diverse and economically disadvantaged population than traditional FFS Medicare.⁷ Reporting on adherence with and violations of non-discrimination provisions, enforced by Department of Health and Human Services Office of Civil Rights (OCR), within MA and traditional Medicare plans will ensure appropriate comparison of the equitability of options offered under the Medicare program.

Data collection and reporting on social determinants of health (SDOH)—or the nonmedical factors such as where people are born, live, learn, work, play, worship, and age—are also needed as they affect a wide range of health, functioning, and quality-of-life outcomes and risks. The identification, documentation, and intervention of such factors is essential for equitable, high-quality, holistic, patient-centered care. In line with CMS's goal to transition virtually all Medicare and Medicaid beneficiaries into accountable care relationships by 2030, ASHA acknowledges the health equity implications of including SDOH risk assessments to risk adjustment in value-based payment systems. Reporting of such data allows accurate comparison of health equity initiatives between traditional Medicare and MA plans.

We also believe data associated with discharge destination based on practice setting should be collected to understand how that might differ between traditional Medicare and MA and its implications for patients' functional outcomes.

Finally, data interoperability through electronic medical records using technology such as Fast Healthcare Interoperability Resources (FHIR) and Application Programming Interface (API) offers enormous promise in data analytics while avoiding the limiting administrative burden that has historically plagued data-sharing efforts.

E. Rationale, goals, and questions that you could address with newly released data and suggestions for how such data could support new action or regulation by CMS

If the data shows that certain patient populations are experiencing adverse events—such as higher rates of denials or delays in prior authorization requests—**CMS should require the MA plan to develop a corrective action plan and consider the imposition of financial penalties, including termination of its contract.**

Data is also needed on the use of MA funds. Data should be collected on rates paid to providers, which many report are significantly lower than traditional Medicare fee-for-service rates.^{8,9} Considering well-documented inappropriate denials and lower provider

payments, it is not surprising that insurance companies are making significant margins off their MA beneficiaries.¹⁰ Data is needed to determine why the funds are not being used to appropriately pay providers and ensure beneficiaries receive medically necessary services. ASHA previously commented on the need for consumer protection policies to “maintain additional guardrails on agent and broker compensation packages”.¹¹ Data and regulations are needed to ensure that MA funds are used for medically necessary services and payment to keep providers in network instead of corporate or broker profits.

F. Detailed information from beneficiary advocates, health care providers, and other stakeholders on common challenges and experiences in the MA program for which limited data are currently available

CMS should engage with state insurance commissioners regarding their experiences with MA plans, such as the number and types of complaints they get from Medicare beneficiaries. CMS should also consider the National Association of Insurance Commissioners’ requests for regulatory authority over the Medicare Advantage market so they can effectively regulate MA plan practices within their states.^{12,13}

In previous comments to CMS, we recommended that all coverage policies developed by MA plans be subject to a public comment process. Despite finalizing that all MA plan coverage policies be publicly available and should not be based on proprietary data, research, or utilization management techniques, **ASHA asserts that transparency is insufficient.** MA plan coverage policies should be subject to the same standard as traditional Medicare local coverage determinations where public comment is solicited and considered in the development of a final policy. Stakeholder engagement should also be the standard.

As mentioned in Section E above, additional data and regulations are needed to ensure that MA funds are used for medically necessary services and payment to keep providers in network instead of corporate or broker profits.

Thank you for your attention to these comments. If you or your staff have questions, please contact Sarah Warren, ASHA’s director for health care policy for Medicare, at swarren@asha.org or Meghan Ryan, ASHA’s director for health care policy for private plans, at mryan@asha.org.

Sincerely,



Tena L. McNamara, AuD, CCC-A/SLP
2024 ASHA President

¹ Centers for Medicare & Medicaid Services. Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

² Centers for Medicare & Medicaid Services. Medicare Program; Contract Year 2025 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; Health Information Technology Standards and Implementation Specifications

³ Morgenson, G., & Cavazuti, L. (2023). "Deny, deny, deny": By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients, say CEOs. NBC News. <https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012>

⁴ Emerson, J. (2023). Becker's Hospital Review. *Hospitals are dropping Medicare Advantage plans left and right.* <https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html>

⁵ ibid

⁶ Appleby, J., & KFF Health News. (2023). *Medicare Advantage increasingly popular with seniors—but not hospitals and doctors.* Fortune Well. <https://fortune.com/well/2023/11/30/medicare-advantage-popular-with-seniors-not-hospitals-doctors/>

⁷ Better Medicare Alliance. (2023). *New Report: Black, Latino, and Asian Beneficiaries Choose Medicare Advantage Over Traditional Medicare.* <https://bettermedicarealliance.org/news/new-report-black-latino-and-asian-beneficiaries-choose-medicare-advantage-over-traditional-medicare/>

⁸ Morgenson, G., & Cavazuti, L. (2023). "Deny, deny, deny": By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients, say CEOs. NBC News. <https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012>

⁹ Appleby, J., & KFF Health News. (2023). *Medicare Advantage increasingly popular with seniors—but not hospitals and doctors.* Fortune Well. <https://fortune.com/well/2023/11/30/medicare-advantage-popular-with-seniors-not-hospitals-doctors/>

¹⁰ KFF. (2023). *Medicare Advantage Insurers Report Much Higher Gross Margins Per Enrollee Than Insurers in Other Markets.* <https://www.kff.org/medicare/press-release/medicare-advantage-insurers-report-much-higher-gross-margins-per-enrollee-than-insurers-in-other-markets/>

¹¹ American Speech-Language-Hearing Association. (2024). *ASHA Comments to CMS Regarding CY 2025 MA NPRM.* <https://www.asha.org/siteassets/advocacy/comments/asha-comments-to-cms-re-cy25-ma-nprm-010324.pdf>

¹² National Association of Insurance Commissioners. (2024). *NAIC Announces 2024 Strategic Priorities.* <https://content.naic.org/article/naic-announces-2024-strategic-priorities>

¹³ National Association of Insurance Commissioners. (2024). *NAIC President Andrew N. Mais: "Not Everyone Gets a Chance to Help. We Do."* <https://content.naic.org/article/naic-president-andrew-n-mais-not-everyone-gets-chance-help-we-do>