



February 9, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-4201-P  
P.O. Box 8013  
7500 Security Boulevard  
Baltimore, MD 21244

RE: 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

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the proposed rule for 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. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

ASHA's members and their employers contract with MA plans to provide services to Medicare beneficiaries; therefore, we are committed to ensuring that regulations protect patients and their health care providers from inappropriate utilization management practices. This rule is critically important because it includes provisions that would clarify the use of utilization management techniques, such as prior authorization, by MA organizations and the plans they develop. As highlighted in a report from the Office of the Inspector General (OIG) in 2022, the inappropriate use of these techniques has jeopardized access to care for beneficiaries who have elected coverage through MA rather than traditional Medicare. In addition, the 117th Congress considered legislation to address these issues given the broad number of stakeholders who have expressed concerns. The attention given to inappropriate utilization management practices in this proposed rule is welcome and ASHA appreciates the opportunity to demonstrate why many of the proposed provisions are necessary and should be finalized.

**III. E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, and 422.138)**

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ASHA appreciates the recognition that utilization management techniques require oversight and clarification to ensure they meet the needs of Medicare beneficiaries. Anecdotally, ASHA hears from its members working in a variety of health care settings that utilization management techniques create confusion for clinicians and patients alike who were not sure if a service is covered and, if so, under what circumstances when the patient is enrolled in an MA plan. Questions about whether or not MA plans must comply with local and national coverage decisions are common. Because these techniques are considered proprietary, it makes it challenging for clinicians and patients to provide the information necessary to receive prior authorization or appeal authorization denials. Perhaps most concerning, utilization management techniques have created an inequitable system for Medicare beneficiaries where those covered by traditional Medicare have access to a service that those enrolled in an MA plan do not.

These techniques take a variety of forms including the use of demographic data—such as age and diagnosis—to route patients to specific settings of care regardless of the patient's and clinical care team's wishes. For example, demographic data may be used to funnel patients with a referral from inpatient rehabilitation facilities to skilled nursing facilities or from skilled nursing facilities to home health. These patients often meet the traditional Medicare criteria for admission to the setting of care selected by the clinical care team but are denied by the plan based on proprietary criteria. While no MA plan prohibits coverage of inpatient rehabilitation services in its policy documentation, the use of these utilization management techniques equates to a de facto prohibition on coverage for these services. These practices are prevalent despite CMS regulations at §422.101(a) and (b) that require MA plans to provide coverage of all basic benefits (services covered under Medicare Parts A and B with limited exceptions) and that MA plans must comply with traditional Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs) applicable in the MA plan's service area.

In the proposed rule, CMS clearly outlines that certain utilization management practices fail to comply with its regulatory expectations. As stated in the rule,

“...MA organizations may not limit coverage through the adoption of policies and procedures—whether those policies and procedures are called utilization management and prior authorization or the standards and criteria that the MA organization uses to assess and evaluate medical necessity—when those policies and procedures result in denials of coverage or payment where the Traditional Medicare program would cover and pay for the item or service furnished to the beneficiary. In addition, this means that limits or conditions on payment and coverage in the Traditional Medicare program— such as who may deliver a service and in what setting a service may be provided, the criteria adopted in relevant NCDs and LCDs, and other substantive conditions—apply to set the scope of basic benefits as defined in § 422.100(c).”

**Therefore, ASHA recommends that CMS finalize its proposal that MA organizations must make medical necessity determinations based on coverage and benefit criteria as specified at § 422.101(b) and (c). Further, MA organizations must cover all basic benefits covered under traditional Medicare and may not deny coverage for basic benefits based on coverage criteria that are not part of local or national coverage determination.**

ASHA recommends that CMS modify its proposal, which establishes the parameters for MA plans to develop internal coverage criteria when coverage criteria are not fully established in applicable Medicare statute, regulation, NCD, or LCD. Of note, CMS is not proposing that plans must release a predetermination explanation and opportunity for the public to comment on the

MA organization's coverage criteria. We believe this does not comport with CMS's stated intention of holding these plans to the same standard as national and local coverage determinations. These policies are subject to a public comment period and ASHA believes coverage policies for MA plans should be held to the same development standards as traditional Medicare coverage policies. **ASHA recommends that CMS reconsider this position and finalize a policy that would require a public comment period for any internal coverage criteria established by MA plans.**

ASHA also supports the inclusion of a proposal that would require MA plans to make coverage decisions on the individual circumstances and clinical presentation of the patient. **ASHA recommends that CMS finalize a change in the regulations that MA organizations must consider the enrollee's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes when making medical necessity determinations.**

CMS provides additional beneficiary protections by outlining the appropriate use of prior authorization. For example, CMS notes in the proposed rule that prior authorization should only be used to confirm the presence of diagnoses or other medical criteria and to ensure that the furnishing of a service or benefit is medically necessary or, for supplemental benefits, clinically appropriate and should not function to delay or discourage care. Additionally, CMS addresses the use of post-payment denials despite a predetermination approval, a common practice that creates significant challenges for clinicians and patients. CMS reiterates guidance at section 10.16 of Chapter 4 of the Medicare Managed Care Manual, which states that if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity. This means that when an enrollee or provider requests a pre-service determination and the plan approves this pre-service determination of coverage, the plan cannot later deny coverage or payment of this approval based on medical necessity. **ASHA recommends that CMS maintain accountability for MA plans who violate this existing requirement.**

### **III.E.5. Mandate Annual Review of Utilization Management (UM) Policies by a UM Committee (§ 422.137)**

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CMS proposes to require MA organizations to establish a Utilization Management (UM) Committee that would be responsible, at least annually, for reviewing the policies and procedures for all utilization management techniques and policies, including prior authorization, used by the MA plan. Further, CMS proposes what elements of the utilization management policies should be reviewed, such as the services to which the management techniques would be applied. The Committee membership would be comprised primarily of physicians.

ASHA supports the proposal to establish a UM Committee including annual review of utilization management techniques to ensure they are reflective of the most current evidence and research available. **However, ASHA believes that the Committee's membership should include nonphysicians including a beneficiary representative and members of the full clinical care team, including audiologists and speech-language pathologists.** While physicians are critical members of this Committee and of clinical care teams, nonphysicians play a critical role in identifying and treating a variety of clinical conditions often seen in the Medicare population including dementia, strokes, Parkinson's, and ALS. Coverage policies should be based on the clinical expertise of the full interprofessional team.

### **III.H. Review of Medical Necessity Decisions by a Physician or Other Health Care Professional with Expertise in the Field of Medicine Appropriate to the Requested Service and Technical Correction to Effectuation Requirements for Standard Payment Reconsiderations (§§ 422.566, 422.590, and 422.629)**

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CMS proposes to modify the types of clinical professionals that must be available to provide review of prior authorization requests, including medical record documentation. Specifically, the revision would require that the reviewer could be a physician or *other health care professional* with the requisite expertise to review the specific services subject to prior authorization and provides several examples of the types of health care professionals who could be involved, such as respiratory therapists. **ASHA recommends CMS adopt this change. The involvement of audiologists and speech-language pathologists in the review of prior authorization requests required for audiology and speech-language pathology services will best protect patient access to care and prevent inappropriate approval or denial of services.**

### **Health Equity in Medicare Advantage (MA) (§§ 422.111 and 422.112)**

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In addition to updates to utilization management practices, CMS also proposes several health equity requirements for MA plans. Taken together, these changes could provide new and important beneficiary protections. ASHA is committed to ensuring health equity and we appreciate CMS's continued efforts to engage on this topic.

In an effort to ensure equitable access to MA services and that these services are provided in a culturally competent manner, CMS is proposing to broaden the categories of patients for which consideration is provided to include individuals:

- with limited English proficiency or reading skills;
- of ethnic, cultural, racial, or religious minorities;
- with disabilities;
- who identify as lesbian, gay, bisexual, or other diverse sexual orientations;
- who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex;
- who live in rural areas and other areas with high levels of deprivation; and
- otherwise adversely affected by persistent poverty or inequality.

#### **ASHA supports this change.**

CMS also proposes to require that MA provider directories include providers' cultural and linguistic capabilities (including American Sign Language, ASL). **ASHA supports this change.**

Finally, CMS proposes to require MA organizations to incorporate one or more activities into their overall quality improvement (QI) program that reduce disparities in health and health care among their enrollees. MA organizations may implement activities such as improving communication, developing and using linguistically and culturally appropriate materials (to distribute to enrollees or use in communicating with enrollees), hiring bilingual staff, community outreach, or similar activities. CMS states its belief that adopting this proposed requirement for MA organizations as part of their required QI programs will align with health equity efforts across CMS policies and programs. **ASHA recommends CMS adopt this proposal.**

Thank you for your consideration of our recommendations. ASHA remains committed to partnering with CMS and other stakeholders to ensure the Medicare program, including Medicare Advantage, remains robust and serves the needs of Medicare beneficiaries. If you or your staff have any questions, please contact Sarah Warren, ASHA's director for health care policy for Medicare, at [swarren@asha.org](mailto:swarren@asha.org).

Sincerely,

A handwritten signature in black ink that reads "Robert M. Augustine". The signature is written in a cursive, flowing style.

Robert M. Augustine, PhD, CCC-SLP  
2023 ASHA President