October 26, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4214-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov

RE: Medicare Program; Implementation of Sections 6219, 6220, and 6224 of the Consolidated Appropriations Act, 2026 (CMS-4214-P)

Dear Administrator Oz:

The Academy of Doctors of Audiology (ADA), a leading national association dedicated to evidence-based audiologic and vestibular care, represents audiologists across the United States who own, manage, and practice in autonomous audiology practices and who treat millions of Medicare patients each year. ADA appreciates the opportunity to comment on the proposed rule implementing sections 6219, 6220, and 6224 of the Consolidated Appropriations Act, 2026 (CAA). Our members see firsthand how provider network design, benefit administration, and directory accuracy determine whether Medicare Advantage (MA) beneficiaries can actually obtain the hearing care they need.

ADA supports CMS's implementation of the Requiring Enhanced and Accurate Lists of (REAL) Health Providers Act and its stated goal of ensuring that "beneficiaries are provided with clear, accurate information on the network of providers available to meet their health care needs."[1] This goal is closely aligned with recommendations ADA has made to CMS for several years. In January 2024, ADA urged CMS to require greater transparency regarding hearing benefit networks, third-party administrators, and vertical ownership relationships in MA,[2] and in May 2024 ADA provided further recommendations in response to CMS's Request for Information on Medicare Advantage Data.[3] ADA has since codified these recommendations in its position statement, *A Call to Action on Coverage of Hearing Care*.[4] Our comments below focus on how the proposed provider directory requirements apply to hearing care, and on related practices that undermine the accuracy and value of hearing benefit network information.

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[1]Centers for Medicare & Medicaid Services, Medicare Program; Implementation of Sections 6219, 6220, and 6224 of the Consolidated Appropriations Act, 2026 (CMS-4214-P), proposed rule, 91 FR 66408 (Oct. 20, 2026), FR Doc. 2026-21420, Docket No. CMS-2026-3533, https://www.regulations.gov/document/CMS-2026-3533-0002

[2]Academy of Doctors of Audiology, comment letter on Medicare Program: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program (CMS-4205-P), Jan. 5, 2024, https://www.regulations.gov/comment/CMS-2023-0187-3003

[3]Academy of Doctors of Audiology, comment on Request for Information on Medicare Advantage Data, May 29, 2024, https://www.regulations.gov/comment/CMS-2024-0008-0268

[4]Academy of Doctors of Audiology, A Call to Action on Coverage of Hearing Care: Principles for Public Policies that Optimize Patient Outcomes (position statement, 2025), https://audiologist.org

Background: Hearing Care in Medicare Advantage

Hearing health is essential to overall health and wellbeing. Approximately 15% of U.S. adults report some difficulty hearing, and disabling hearing loss affects about 22% of adults aged 65 to 74 and approximately 55% of those aged 75 and older.[5] Hearing loss is associated with diabetes, cardiovascular disease, cognitive decline, and other serious health conditions.[6]

Diagnostic audiologic evaluations are covered under Medicare Part B, and MA plans must cover all medically necessary services that traditional Medicare covers.[7] Hearing aids and examinations for the purpose of prescribing, fitting, or changing hearing aids are excluded from traditional Medicare,[8] and MA plans instead offer them as supplemental benefits. In 2026, 98% of individual MA plans offer some type of hearing benefit,[9] and 35.2 million people, or 55% of eligible Medicare beneficiaries, are enrolled in MA.[10] Hearing benefits are also a central feature of MA marketing: more than half of MA television advertisements reviewed by the Kaiser Family Foundation specifically promoted hearing benefits.[11]

MA organizations commonly delegate their supplemental hearing benefits to hearing benefit third-party administrators (TPAs). These entities maintain networks outside of the primary insurer's network, set reimbursement and product pricing, define which products and services are available to enrollees, and are frequently owned by or affiliated with hearing aid manufacturers.[12] Because of their focus on the sale of hearing aids, these arrangements place little value on diagnostic testing, cerumen management, verification and validation, and treatment services such as auditory rehabilitation and tinnitus management, despite the fact that these services are often crucial to optimal clinical outcomes.[13,14] As a result, the beneficiary-facing directory for hearing care is often maintained by an entity other than the MA organization, under standards that are not clearly governed by the existing directory requirements at § 422.111. The REAL Health Providers Act gives CMS a timely opportunity to close that gap.

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[5]National Institute on Deafness and Other Communication Disorders, Quick Statistics About Hearing, https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing

[6]J. Besser, M. Stropahl, E. Urry, S. Launer, Comorbidities of hearing loss and the implications of multimorbidity for audiological care, Hearing Research 369 (2018): 3–14, https://doi.org/10.1016/j.heares.2018.06.008

[7]Social Security Act § 1852(a)(1); 42 CFR 422.101, https://www.ecfr.gov/current/title-42/section-422.101; Centers for Medicare & Medicaid Services, Understanding Medicare Advantage Plans, https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf

[8]Social Security Act § 1862(a)(7), https://www.ssa.gov/OP_Home/ssact/title18/1862.htm; 42 CFR 411.15(d), https://www.ecfr.gov/current/title-42/section-411.15

[9]Kaiser Family Foundation, Medicare Advantage 2026 Spotlight: A First Look at Plan Premiums and Benefits, https://www.kff.org/medicare/medicare-advantage-2026-spotlight-a-first-look-at-plan-premiums-and-benefits/

[10]Kaiser Family Foundation, Medicare Advantage in 2026: Enrollment Update and Key Trends, https://www.kff.org/medicare/fact-sheet/medicare-advantage/

[11]Kaiser Family Foundation, How Health Insurers and Brokers Are Marketing Medicare, https://www.kff.org/report-section/how-health-insurers-and-brokers-are-marketing-medicare-report

[12]See note 2 above (ADA comment on CMS-4205-P).

[13]See note 4 above (ADA, A Call to Action on Coverage of Hearing Care).

[14]A. Brodie, B. Smith, J. Ray, The impact of rehabilitation on quality of life after hearing loss: a systematic review, European Archives of Oto-Rhino-Laryngology 275(10) (2018): 2435–2440, https://pmc.ncbi.nlm.nih.gov/articles/PMC6132942/

I. Comments on Proposed Provider Directory Provisions

1. Apply the Directory, Accuracy, and Cost Sharing Requirements to Supplemental Benefit Networks, Including Networks Delegated to Third-Party Administrators

The proposed definition of "provider directory information" at § 422.2 refers to information enrollees need to access "covered benefits" from providers furnishing "items and services covered under such plan." The preamble notes only that CMS "may consider" providers furnishing supplemental benefits when identifying specialty types for the accuracy sample.[15] The proposed rule does not state whether the verification, updating, accuracy analysis, public reporting, and cost sharing protection requirements apply to providers who furnish supplemental benefits, or to networks maintained by first tier or downstream entities on the MA organization's behalf.

Supplemental benefits are benefits "covered under such plan," and enrollees choose plans in part on the basis of them. An enrollee who selects an MA plan because a trusted audiologist appears in its hearing network is harmed in exactly the way the statute contemplates if that listing is wrong. Consistent with §422.504(i), the MA organization retains ultimate responsibility for functions it delegates, including the maintenance of provider networks and directories.[16]

ADA is also concerned that MA coverage documents and directories typically do not distinguish between a diagnostic audiologic evaluation covered under the medical benefit and a "routine hearing exam" offered under the supplemental benefit. Beneficiaries are frequently steered exclusively into the TPA's network for a "free" routine exam conducted for the purpose of fitting and selling a hearing aid and are seldom informed that they are entitled to a diagnostic audiologic evaluation under their medical benefit, or which network providers may furnish it.[17]

ADA Recommendations:

- Clarify in the final rule, at §§ 422.2 and 422.123, that provider directory information includes providers furnishing supplemental benefits, including hearing benefits, and that the verification, updating, removal, and accuracy analysis requirements apply to those providers.
- Clarify that these requirements apply regardless of whether the network is maintained by the MA organization or delegated to a first tier, downstream, or related entity such as a hearing benefit TPA, and that the MA organization remains accountable for the accuracy of any delegated directory.
- Require that supplemental benefit providers appear in, or be directly linked from, the MA organization's online provider directory and meet the same data element and accuracy standards.
- Require directories to identify which network providers furnish diagnostic audiologic evaluations under the medical benefit, separately from providers listed for the supplemental routine hearing exam, and to notify enrollees when they must go through a TPA or third-party network to obtain a benefit.

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[15] See note 1 above (CMS-4214-P proposed rule).

[16] 42 CFR 422.504(i), https://www.ecfr.gov/current/title-42/section-422.504

[17] See note 2 above (ADA comment on CMS-4205-P).

- Clarify that the cost sharing protections at § 422.124 apply to items and services furnished under supplemental benefits when an enrollee relied on an inaccurate directory listing.

2. Identify Audiology as a Provider Specialty Type for Accuracy Sampling

CMS seeks comment on whether there are other provider specialty types that should be considered provider specialty types with high provider directory inaccuracy rates, and asks commenters to identify the relevant Medicare specialty codes and National Uniform Claim Committee (NUCC) taxonomy codes.[18] ADA members consistently report being listed in MA and hearing benefit directories for plans they do not participate in, at locations where they do not practice, or with outdated contact information, as well as being omitted from directories for plans in which they are contracted. ADA has also documented that enrollees are often referred by benefit administrators to providers who do not offer the full range of hearing aid brands advertised in the plan's formulary.[19]

ADA Recommendations:

- Include audiology as a provider specialty type with high provider directory inaccuracy rates under proposed § 422.123(d)(2)(ii), identified using Medicare specialty code 64 (Audiologist) and NUCC taxonomy code 231H00000X (Audiologist) and its subspecialty codes.
- Include providers furnishing supplemental hearing benefits within the sampling frame under proposed § 422.123(d)(2)(i).

ADA would welcome the opportunity to share member-reported directory inaccuracy data with CMS to inform its annual technical guidance.

3. Require Directories to Identify Provider Type and Credentials

The proposed definition requires each listing to include the provider's "specialty." In hearing care, providers with very different education, licensure, and scope of practice are frequently listed together as "hearing care professionals." Hearing benefit plans are often built on the assumption that every hearing care professional has the same value and utility.[20] A beneficiary cannot tell from such a listing whether a provider is a licensed audiologist qualified to perform diagnostic evaluations, or a dispenser whose scope is limited to the fitting and sale of hearing aids. This distinction directly affects whether the beneficiary can access the covered service they need. ADA previously recommended that CMS require ready access to contact information and provider type for every participating hearing benefit provider.[21]

ADA Recommendations:

- Clarify that the "specialty" element must identify the provider type and professional credential (for example, "Audiologist") using Medicare specialty or NUCC taxonomy designations, and must not group distinct provider types under generic labels.
- Confirm that the 90-day verification, 30-day updating, and 5-business-day removal requirements apply equally to hearing benefit networks.

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[18] See note 1 above (CMS-4214-P proposed rule).

[19] See note 2 above (ADA comment on CMS-4205-P).

[20] See note 4 above (ADA, A Call to Action on Coverage of Hearing Care).

[21] See note 2 above (ADA comment on CMS-4205-P).

4. Expand the Common Ownership or Control Disclosure to Hearing Benefit Administrators, Manufacturers, and Affiliated Distribution Channels

ADA strongly supports CMS's proposal to add common ownership or control disclosure as a required element of provider directory information. As CMS notes, vertical integration "may affect care delivery arrangements, referral patterns, and negotiated charges or payment arrangements."[22] These concerns are especially acute in hearing care. The five largest global hearing aid manufacturers control more than 90% of the hearing aid market, and four of them own or are financially affiliated with hearing benefit plans, TPAs, or networks:[23]

Hearing Aid Manufacturer	Owned Benefit Plan, Administrator, or Network	Owns Hearing Aid Clinics?
Demant	Bird Song; Your Hearing Network	Yes
GN	Nations Benefits; Pending Merger with Amplifon[24]	Yes
Sonova	None	Yes
Starkey	Start Hearing (formerly American Hearing Benefits)	Yes
WS Audiology	TruHearing; Hearing Care Solutions	Yes

Source: ADA comment on CMS-4205-P (Jan. 5, 2024).

Manufacturers have cited revenue generation and market growth as primary reasons for vertical expansion into managed care.[25] In many MA plans, the entity making hearing benefit decisions therefore has a direct financial interest in hearing aid sales, yet enrollees have no knowledge of the relationship among the manufacturer, the benefit administrator, and, in some cases, the retail clinic and provider to which they are referred. CMS specifically solicits comments on the types of affiliate and common-control relationships the disclosure should capture and on the proposed model language.[26]

ADA Recommendations:

- Extend the disclosure to network providers and locations that are owned or controlled by, or affiliated with, any entity administering a benefit on the MA organization's behalf, including hearing benefit TPAs.
- Require disclosure when a network provider, retail location, or online or virtual provider is affiliated with a manufacturer of the products furnished under the benefit, such as a hearing aid manufacturer.
- Require the directory to identify, in plain language, any third party that administers a supplemental benefit, and to state when that administrator is affiliated with listed providers or product manufacturers. Suggested model language: "This hearing benefit is administered by

[22]See note 1 above (CMS-4214-P proposed rule).

[23]See note 2 above (ADA comment on CMS-4205-P).

[24] Amplifon Press Release, March 16, 2026. https://corporate.amplifon.com/en/investors/press-releases/extraordinary-press-release

[25]MedCity News, How device makers are responding to Medicare Advantage's quiet revolution in hearing health (Oct. 2019), https://medcitynews.com/2019/10/how-device-makers-are-responding-to-medicare-advantages-quiet-revolution-in-hearing-health

[26]See note 1 above (CMS-4214-P proposed rule).

[administrator]. [Administrator] is under common ownership or control with [manufacturer/provider]."

5. Use the Section 6224 PBM Framework as a Model for Hearing Benefit Administrators

ADA recognizes that section 6224 applies only to pharmacy benefit managers (PBMs) in Part D. However, the problems Congress and CMS identify in the PBM market, including affiliate steering, opaque compensation, payment differentials between affiliated and unaffiliated providers, and compensation tied to product price, closely mirror the practices ADA members encounter with hearing benefit TPAs. Under the proposed rule, PBM compensation would be limited to bona fide service fees that are flat dollar amounts reflecting fair market value and not directly or indirectly based on drug price, and manufacturer rebates received by a PBM must be fully passed through to the plan sponsor.[27]

No comparable protections exist for hearing benefits. Hearing benefit administrators typically do not pay providers separately for the hearing examination. Instead, they customarily pay a fitting fee only after a hearing aid is purchased. Additionally, hearing benefit administrators frequently pay higher fitting fees for higher-technology (higher priced) devices, even though fitting those devices does not require additional time or effort. ADA has also documented hearing aid manufacturer rebate programs that pay providers more for recommending premium-tier devices to managed care patients, including MA patients.[28] These arrangements conflict with ADA's Code of Ethics, may implicate the federal Anti-Kickback Statute, and compromise clinical judgment in favor of the financial interests of the manufacturer, administrator, and provider rather than the patient/beneficiary.

ADA Recommendations:

ADA urges CMS to consider, in future MA rulemaking, applying comparable standards to entities that administer supplemental hearing benefits, including:

- Compensation limited to bona fide, fair-market-value service fees that are not tied to the price, brand, technology tier, or volume of products dispensed.
- Disclosure to the MA organization and CMS of affiliate relationships and of payment rates to affiliated versus unaffiliated providers.
- A prohibition on steering enrollees to affiliated providers, retail locations, or affiliated online or virtual channels.
- A prohibition on requiring audiologists, as a condition of network participation, to purchase products from sources owned by or affiliated with the administrator.
- A prohibition on provider fee differentials and manufacturer rebate programs that create real or perceived conflicts of interest or incentivize specific product types, brands, or technology tiers.

II. Related Recommendations on Hearing Benefit Administration in Medicare Advantage

The following recommendations address practices that directly undermine the accuracy and value of the network information the REAL Health Providers Act is designed to protect. Where they extend beyond

[27] See note 1 above (CMS-4214-P proposed rule).

[28] See note 2 above (ADA comment on CMS-4205-P).

the scope of this proposed rule, ADA respectfully requests that CMS address them through future rulemaking, the annual MA policy and technical changes rule, or sub-regulatory guidance.

6. Require Separate Coverage and Payment for Diagnostic Audiologic Evaluations

Under section 1852(a)(1) of the Act and § 422.101, MA plans must cover all items and services covered under Part B, including medically necessary diagnostic audiologic evaluations. ADA understands that MA bids are therefore required to include the diagnostic audiologic assessment.[29] Yet, ADA members routinely encounter MA arrangements in which diagnostic audiology codes, such as CPT® 92557 (comprehensive audiometry threshold evaluation and speech recognition), are included in the fees paid to the TPA for administering the hearing benefit or bundled into the hearing aid dispensing fee.[30] In practice, audiologists are required to perform diagnostic evaluations for no separate payment, or the MA organization denies the claim on the basis that the service is included in the hearing benefit, even when the evaluation was medically necessary and unrelated to the fitting of a hearing aid. This shifts the cost of a Part B basic benefit onto the audiologist or the beneficiary and may place audiologists in a non-compliant position under Medicare rules and professional ethical standards.

ADA Recommendations:

- Clarify that MA organizations, and any TPA acting on their behalf, may not require a qualified audiologist to furnish medically reasonable and necessary diagnostic audiologic evaluations for no separate, distinct payment.
- Clarify that charges for these Medicare Part B services may not be bundled into, or made inclusive of, a supplemental hearing aid dispensing or professional fee, or into the capitated or administrative fees paid to a TPA.
- Require MA organizations to ensure that delegated hearing benefit arrangements separately identify and reimburse basic-benefit diagnostic services and incorporate this requirement into CMS program audit protocols.
- Require MA plans to notify enrollees of the audiology services covered under their medical benefit, in addition to any supplemental routine hearing exam.

7. Protect Beneficiaries and Audiologists with Respect to Non-Covered Services

Under 42 CFR 422.100(c)(2)(ii)(B), a supplemental benefit requires that the MA organization incur a non-zero direct medical cost, and the Medicare Managed Care Manual states that the requirement is not met if the plan incurs only an administrative cost.[31] ADA remains concerned that many MA hearing aid "benefits" are discount programs presented as funded coverage, often under a so-called copayment structure in which the enrollee is in fact responsible for the full cost of all products and services.[32] Because supplemental benefits are financed through rebate dollars or enrollee premiums, beneficiaries may be paying for hearing "benefits" that cost the plan sponsor nothing.

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[29]See note 2 above (ADA comment on CMS-4205-P).

[30]See note 4 above (ADA, A Call to Action on Coverage of Hearing Care).

[31]42 CFR 422.100(c)(2)(ii)(B), https://www.ecfr.gov/current/title-42/section-422.100; Medicare Managed Care Manual, Chapter 4, § 30.1, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf

[32]See note 2 above (ADA comment on CMS-4205-P).

These arrangements also misuse basic insurance terminology. A benefit is a health care item or service covered under a health insurance plan,[33] and a copayment is a cost-sharing structure in which the insured pays a fixed amount and the insurer pays the remainder.[34] Under many hearing discount programs, the TPA sets the fee the audiologist may charge, labels the enrollee's payment a "copay," and prohibits the audiologist from charging separately for services the program does not cover. Services essential to good outcomes, including counseling, communication needs assessment, verification and validation, auditory rehabilitation, cerumen management, and tinnitus management, frequently fall into this category. The result is that beneficiaries are misled about what their plan covers, audiologists cannot be reimbursed for necessary care, and that care too often goes undelivered, including for beneficiaries who have purchased hearing aids they are unable to use effectively.[35,36]

ADA Recommendations:

- Enforce the non-zero direct medical cost requirement for supplemental hearing benefits and clarify that an item or service is "covered" only if the MA organization is obligated to pay a reasonable, non-nominal amount for it, including amounts that would be payable but for a deductible, copayment, coinsurance, frequency limitation, or annual or lifetime maximum.
- Prohibit MA organizations and TPAs from establishing nominal payments for otherwise non-covered services in order to treat those services as covered, and from using the terms "benefit" or "copay" to describe a discount program.
- Require hearing discount programs to state in bold and prominent type on all marketing and enrollee materials that the program is not insurance, and to identify in plain language which items and services are covered, which are discounted, and which are non-covered.
- Prohibit MA organizations and TPAs from setting or determining fees for any non-covered audiology or hearing service, and from requiring audiologists, as a condition of participation, to furnish non-covered services for free, at a set fee, or at a discount from their usual and customary fee.
- Affirm that an audiologist may, with the beneficiary's written informed consent, obtained before the service is furnished, charge the beneficiary privately for items and services not covered under the plan's basic or supplemental benefits, and that MA organizations and TPAs may not contractually prohibit this.
- Require that reimbursement rates and any applicable cost sharing for each covered service, product, and material be clearly itemized in the provider contract, and that services the MA organization or TPA fails to identify as covered be treated as non-covered.

8. Prohibit Involuntary Network Leasing and Require Consent for Directory Listings

Network leasing arrangements, in which a TPA or plan grants another entity access to its contracted provider network, are a significant and often overlooked source of directory inaccuracy. Audiologists

[33]HealthCare.gov, Glossary: Benefits, https://www.healthcare.gov/glossary/benefits

[34]National Association of Insurance Commissioners, Consumer Insurance Glossary, https://content.naic.org/consumer_glossary.htm

[35]See note 4 above (ADA, A Call to Action on Coverage of Hearing Care).

[36]See https://pmc.ncbi.nlm.nih.gov/articles/PMC3665209/, as cited in ADA, A Call to Action on Coverage of Hearing Care.

frequently discover that they are listed in the directories of plans and programs with which they never contracted, under terms they never accepted. These listings are inaccurate by definition: the audiologist has not agreed to furnish services under that plan's terms, and the beneficiary who relies on the listing may be denied the expected in-network access, exposing the MA organization to cost sharing protection claims under proposed § 422.124.[37]

ADA Recommendations:

- Clarify that an MA organization may list a provider in its directory only where the provider has a direct agreement with the MA organization or its delegated entity, or has given express written consent to participate in that specific plan arrangement.
- Require that any audiologist, party to a provider network contract, be permitted to decline participation in third-party network access (network leasing) arrangements, and prohibit MA organizations and TPAs from changing, diminishing, or terminating an audiologist's participation status because of that decision.
- Require any third party granted access to a provider network to comply with all terms of the underlying provider contract.
- Treat listings arising from leased network arrangements to which the provider has not consented as inaccurate for purposes of the accuracy analysis and scoring under proposed §422.123(d).

Conclusion

ADA commends CMS for its work to make MA provider directories accurate, transparent, and accountable. Hearing care is a clear example of where accurate network information, transparent ownership relationships, and fair benefit administration determine whether beneficiaries can access the care to which they are entitled. ADA urges CMS to ensure that the final rule reaches supplemental hearing benefits and the third parties that administer them.

ADA appreciates the opportunity to comment and would welcome the opportunity to meet with CMS administrators to discuss these recommendations. Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org for more information, or if further assistance can be provided.

Sincerely,

Jill Davis, Au.D.	Kim Cavitt, Au.D.	Stephanie Czuhajewski, MPH, CAE
President	Reimbursement Policy Chair	Executive Director

[37] See note 4 above (ADA, A Call to Action on Coverage of Hearing Care).