September 12, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), I am writing in response to the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule.

ASHA is the national professional, scientific, and credentialing association for 241,000 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. Many of ASHA's members provide services to patients covered under Medicare Part B and, as a result, have a keen interest in ensuring these payment policies are reflective of their cost and value.

ASHA's comments focus on the following key areas:

- Summary of Costs and Benefits (Section I.C.)
- Determination of Practice Expense (PE) Relative Value Units (Section II.B.)
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Section II.D.)
- Valuation of Specific Codes (II.E.)
- Determination of Malpractice (MP) Relative Value Units (RVUs) (Section II.M.)
- Geographic Practice Cost Indices (GPCIs) (Section II.N.)
- Medicare Shared Savings Program (MSSP) (Section III.F.)
- Updates to the Quality Payment Program and Medicare Promoting Interoperability Program (Section IV.)

I.C Summary of Costs and Benefits

CMS outlines two conversion factors (CFs) for calendar year CY 2026—$33.59 for qualifying alternative payment model (APM) participants (QPs) and $33.42 for clinicians who are not QPs. These CFs reflect the one-time legislative update of 2.5% as well as an annual update methodology finalized in the Medicare Access and Chip Reauthorization Act (MACRA), which ties payment updates for 2026 and beyond to APM participation.

ASHA appreciates CMS' proposed CF updates (0.75% for qualifying APMs and 0.25% for non-qualifying providers). However, we remain deeply concerned that these modest increases are insufficient to offset the impact of previous budget neutrality-driven cuts, newly proposed policies that will reduce payments to various services, and the rising practice costs to provide care. Most ASHA members have limited opportunities to participate in qualified APMs and thus will not benefit from the higher APM CF. In addition, many of the proposed changes to the geographic price cost indices (GPCIs) and the relative value units (RVUs) of Current Procedural Terminology (CPT©) codes used by audiologists and SLPs are inappropriately and arbitrarily reduced in this proposed rule.

ASHA recognizes that Congress must address budget neutrality requirements and provide an inflationary update to the MPFS. In the meantime, CMS can help mitigate the impact of budget neutrality adjustments by reevaluating its utilization assumptions for G2211 (visit complexity inherent to evaluation and management services). CMS currently assumes G2211 utilization at 30–50% of office evaluation and management (E/M) visits. This overestimation has magnified budget neutrality adjustments and driven deeper, across-the-board fee schedule cuts than warranted. According to the American Medical Association (AMA), this assumption effectively tripled the budget neutrality impact, resulting in roughly $1 billion in unintended annual payment reductions.[1]

Because audiologists and SLPs cannot bill G2211, they absorb CF cuts without any offsetting revenue. This has compounded nearly 30% cumulative PFS reductions since 2011 and escalating practice costs, with especially severe effects on small, community-based providers and access in rural and underserved areas. While Congress has repeatedly intervened to avert the worst consequences, a long-term policy solution is critically needed. **Therefore, ASHA urges CMS to reassess and correct G2211 funding assumptions prospectively and to redirect the associated dollars to high-volume specialty services, including audiology and speech-language pathology.** This targeted and systematic reallocation would relieve unwarranted pressure on specialties who do not bill E/M services, stabilize outpatient provider practices, preserve beneficiary access to medically necessary speech, language, swallowing, and hearing services, and better align payment policy with CMS' access and quality goals.

II.B. Determination of PE RVUs

CMS proposes several refinements to the practice expense (PE) valuation methodology. The complexity and cumulative impact of these changes could substantially reduce the value of the services audiologists and SLPs provide. ASHA is concerned that CMS has not provided sufficient rationale to justify these refinements. Therefore, we recommend that CMS not adopt them in 2026 and instead work with stakeholders to identify a methodology that achieves our mutual goals of protecting the Medicare trust fund, appropriately values the services clinicians provide, and maintain access to care for Medicare beneficiaries.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology: Physician Practice Information (PPI) and Clinician Practice Information (CPI) Surveys

ASHA acknowledges CMS' efforts to ensure accurate representation of practice expense per hour (PE/HR) data and cost sharing for MPFS ratesetting. CMS expressed concern that the existing process, used by the American Medical Association (AMA), is deficient given the MPFS's budget-neutral structure. Specifically, CMS worries that inaccuracies in PE/HR data for some specialties could distort the overall pool of practice expense resources, leading to misvaluation and inequitable payment across services. While ASHA agrees that some process improvements may be warranted, we oppose the proposed changes. They do not reflect the realities of clinical practice and would undermine the AMA's CPT code development and valuation process—the primary mechanism that ensures transparency and stakeholder participation.

CMS also questions the accuracy, utility, and suitability of the PPI and CPI surveys as the basis for PE/HR data, citing low response rates, concerns about representativeness, small sample sizes, lack of comparability with earlier data, potential measurement errors, and incomplete submissions. While participation challenges are real, the data from these surveys remain uniquely valuable in capturing the true costs of delivering care. The AMA deployed the updated surveys in 2024 and submitted the results to CMS for consideration in establishing PE/HR data and cost shares for CY 2026. Despite acknowledging limitations in the current methodology, CMS proposes to disregard the new data and continue relying on PE/HR data collected in 2008.

Reliance on 2008 survey data undermines CMS' stated goal of improving payment accuracy. That data—now 18 years old—reflects a health care system that no longer exists. Since then, new technologies and advanced equipment have become integral to clinical practice, improving patient care but also increasing costs to providers. Labor costs have risen substantially, and inflation has increased both direct and indirect expenses. Continuing to base payment on outdated data ignores these realities and risks systematically undervaluing the true costs of providing services.

ASHA therefore respectfully urges CMS to work collaboratively with stakeholders to develop a transparent and accurate methodology for future years. Without timely updates to practice expense inputs, CMS cannot ensure that the MPFS reflects contemporary clinical practice and adequately supports patient access to care.

Update to Practice Expense (PE) Methodology - Site of Service Differential Facility PE RVU

In the proposed rule, CMS states that it is not appropriate to allocate the same amount of indirect practice expense (PE) per work RVU for services furnished in facility versus nonfacility settings, arguing this approach does not reflect current practice trends. To support this conclusion, CMS notes that fewer than half of physicians now own and maintain an office practice, with most employed in facility-based settings such as outpatient hospital departments (HOPDs). Based on this rationale, CMS proposes that beginning in CY 2026, the facility PE RVUs allocated based on work RVUs be reduced to half the amount allocated in the nonfacility setting.

This proposal would disproportionately reduce payment for audiology services delivered in facility settings, including inpatient rehabilitation and skilled nursing facilities. While ASHA

appreciates CMS' intent to update methodology to reflect changing practice environments, **we strongly oppose this proposed reduction for several reasons**:

1. **Arbitrary Reduction:** The proposed 50% cut is arbitrary and unsupported by a clear rationale or data analysis. CMS has not demonstrated why a 50% reduction is justified or provided evidence that the current methodology materially overstates facility PE costs.
2. **CPT Code Development Already Accounts for Efficiencies:** The CPT/RUC process includes mechanisms to account for efficiencies across care settings, making additional across-the-board cuts unnecessary and duplicative.
3. **Comparable Costs Across Settings:** The proposal assumes meaningful cost differences between facility and nonfacility care delivery. In reality, the resources required to provide audiology services in both settings are not substantially different. The proposal risks penalizing providers in facilities without acknowledging the true cost of service delivery.

For these reasons, ASHA strongly urges CMS to **maintain the current facility-based PE RVUs** and avoid arbitrary reductions that threaten access to critical audiology services.

Use of Outpatient Prospective Payment System (OPPS) data for MPFS Ratesetting

ASHA supports CMS' broader efforts to promote transparency across care settings but has significant concerns with the proposal to replace elements of the current AMA Relative Value Update Committee (RUC) process with data from the Outpatient Prospective Payment System (OPPS).

The AMA RUC process provides a transparent, well-established methodology for capturing practice expenses across services. RUC surveys collect clinical staff time and equipment cost data directly from the clinicians who furnish these services, ensuring real-world, accurate, and up-to-date information. This is the **only platform where practicing clinicians—including small practices and solo practitioners—can share data and perspectives** on the costs of delivering care.

By contrast, reliance on **hospital-based OPPS data** would skew results in several problematic ways:

- **Economies of Scale:** Hospitals absorb costs differently than small and solo practices. OPPS data reflects large-scale operations and does not capture the financial realities of community-based providers.
- **Structural Differences in Payment Systems:** OPPS pays based on Ambulatory Payment Classifications (APCs), which bundle services into broad categories. In contract, the MPFS pays per service, reflecting specific provider work, practice expense, and malpractice costs. APC-based payments cannot accurately capture the nuanced costs of highly specialized services billed under the MPFS.
- **Risk of Devaluing Clinician Work:** OPPS combines overhead costs with professional work costs, conflating two distinct components and potentially undervaluing the clinician's direct contribution.

Using OPPS data to set MPFS rates is like forcing a round peg into a square hole. The payment systems are structurally different, serve different purposes, and reflect different types of costs.

Importing hospital-based data into the MPFS framework will inevitably distort rates and jeopardize the financial viability of clinicians practicing outside the hospital setting.

Therefore, ASHA urges CMS to reconsider this proposal and pursue a methodology that maintains the integrity of the RUC process; accurately captures costs for services delivered in outpatient office settings; and incorporates stakeholder input to ensure ratesetting reflects real-world practice across diverse care settings.

Replacing the established process with OPPS data would introduce only inaccuracies, penalize small practices, and devalue the professional work of audiologists and SLPs. Instead, CMS should build on the transparency principles it seeks to advance by refining—not replacing—the existing methodology.

PE RVU Methodology: Low Volume Service Codes

ASHA appreciates CMS' ongoing efforts to improve the stability of PE and malpractice (MP) RVUs for low-volume services. Several low-volume services provided by audiologists have been particularly susceptible to large fluctuations in PE RVUs and, as such, we are indicating our support on the proposed specialty overrides for those services in the following table.

CPT Code	Descriptor	CY 2026 Anticipated Specialty	ASHA Comment
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	Otolaryngology	Agree
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	Otolaryngology	Agree
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	Otolaryngology	Agree
92572	Staggered spondaic word test	Audiologist	Agree
92596	Ear protector attenuation measurements	Audiologist	Agree
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	Audiologist	Agree
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	Audiologist	Agree
92621	Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)	Audiologist	Agree

92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	Audiologist	Agree

II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

ASHA applauds CMS' proposal to reduce its current review process for adding services to the telehealth services list from five steps to three. The current process is somewhat confusing and streamlining it benefits all stakeholders. We also agree that steps one through three provide "sufficient guardrails" to ensure quality patient care.

CMS further reinforces the value of revising its current review process by stating in the proposed rule: "*We expect that physicians and other practitioners would consider the entirety of the circumstances, including the clinical profile and needs of the beneficiary, to determine the appropriate modality for furnishing the service*."

ASHA fully agrees with CMS. In our annual submissions requesting the inclusion of audiology and speech-language pathology services to the permanent telehealth services list, we have consistently highlighted the importance of clinical judgement regarding the use of telehealth services. We also note that audiologists and SLPs are recognized as qualified telehealth providers not only because of their education and expertise but also because of the ethical standards they adhere to, which require telehealth services to meet the same quality standards as in-person care. In determining whether telehealth is appropriate, clinicians use a patient-centered decision-making process that accounts for clinical needs, access to technology, social barriers, and patient preference—ensuring care remains safe, effective, and tailored to individual circumstances.[2]

CMS has also requested feedback on the quality and safety of delivering services via telehealth. As highlighted in our February 2025 request letter, ASHA has reviewed claims data, member survey data, medical literature, and registry data to assess both clinical outcomes and patient satisfaction with telehealth services. Across these sources, the evidence consistently demonstrates that telehealth outcomes of care are at least comparable to in-person services. Patients also report high levels of satisfaction and additional benefits—such as reduced wage loss and lower travel costs. **For these reasons, we strongly urge CMS to permanently add audiology and speech-language pathology services to the authorized telehealth services list.**

We also support CMS' proposal to automatically **transition all provisionally approved telehealth services to the permanent list under the new three-step process.** This change will help ensure Medicare beneficiaries maintain access to a robust telehealth benefit—including audiology and speech-language pathology services—once Congress formally includes these professionals as authorized telehealth providers, which it has repeatedly done since 2020.

In addition, ASHA requests that if CMS decides not to finalize the proposed three-step review process or the automatic inclusion policy, it should clearly state that all currently covered telehealth services, including those provided by audiologists and SLPs, will continue to be covered in 2026.

Finally, **we support CMS' proposal to add auditory osseointegrated sound processor services (CPT codes 92622-92623) to the telehealth services list and thank CMS for recognizing the value of these as telehealth services.**

Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS proposes to update the definition of direct supervision for services billed "incident to" a physician, allowing supervision through real-time audio/video communication technology. This change would make permanent the flexibility first introduced during the COVID-19 public health emergency and later refined in the 2025 MPFS rule.

Although relatively uncommon, some SLPs do furnish services "incident to" a physician. Expanding the definition of direct supervision as proposed would ensure Medicare beneficiaries continue to have access to these services. Importantly, the criteria CMS finalized in 2025 for adding services to the telesupervision list apply directly to speech-language pathology services. In our comments on the 2025 proposed rule, ASHA highlighted this point and urged CMS to apply those criteria permanently. Specifically, CMS' finalized criteria are:

1. The service does not ordinarily require the presence of the billing practitioner.
2. The service does not require direction by the supervising practitioner to the same degree as other services furnished under direct supervision.
3. The service is not typically performed directly by the supervising practitioner.

SLPs in private practice—as well as in hospitals, skilled nursing facilities, and other settings—routinely perform these services independently, consistent with their clinical training, scope of practice, and state law, without physician supervision. Medicare Part B utilization data also confirms that these services are overwhelmingly furnished by SLPs rather than physicians. For example, in 2023, CPT code 92507 (speech, language, communication treatment, individual) and CPT code 92523 (speech and language evaluation) were billed by SLPs more than 98% of the time.

While CMS did not finalize permanent telesupervision of "incident to" services beyond 2025, we are encouraged that this proposal reflects recognition of our continued collaboration on the issue. ASHA urges CMS to finalize this policy on a permanent basis, effective for services furnished on or after January 1, 2026.

II.E. Valuation of Specific Codes

Proposed Efficiency Adjustment

ASHA strongly opposes CMS' proposal to apply a 2.5% "efficiency adjustment" to work RVUs and corresponding intraservice time for selected non–time-based services beginning in CY 2026, with potential reapplication every three years. This policy lacks transparency, is unsupported by evidence, and conflicts with established valuation processes. It threatens to destabilize the resource-based relative value scale (RBRVS) that underpins the MPFS, while exacerbating the financial strain already created by the Multiple Procedure Payment Reduction (MPPR) policy and repeated negative payment updates. The likely outcome would be diminished patient access, particularly in rural and underserved communities.

ASHA strongly urges CMS to withdraw this proposal. If CMS moves forward despite these concerns, we recommend substantial revisions to ensure clarity, fairness, and evidence-based policymaking.

Inconsistencies in Terminology

CMS uses the terms "time-based," "non-time-based," "timed," and "untimed" interchangeably, in ways that conflict with CPT definitions and established medical practice. This ambiguity creates confusion, invites arbitrary code reclassification, and undermines consistency.
For example, CMS states that telehealth services are excluded from the adjustment—yet includes telehealth codes on the impacted list. Such contradictions erode trust in the methodology and create unnecessary uncertainty for providers.

If CMS finalizes this policy, it must publish:

- clear, standardized definition of these terms;
- transparent criteria for adding or removing codes from the adjustment list;
- an explanation of how CMS determines when a code has reached "maximum" efficiency; and
- corrected, accurate list of codes aligned with these definitions and criteria.

Impact on Therapy Services

Therapy codes already face reductions under MPPR, which accounts for efficiencies when multiple services are delivered. Imposing an additional "efficiency" cut would double-penalize these therapy services without justification. Therefore, ASHA strongly urges CMS to **exempt all codes designated as "sometimes" or "always" therapy services from the efficiency adjustment**, if finalized.

Established Valuation Process

CMS asserts that the AMA/RUC has not "effectively addressed" valuation in nearly two decades. This is inaccurate. The RUC employs a robust, systematic, and evidence-based review process that includes potentially misvalued code screens, new-technology tracking, site-of-service change reviews, and high-expenditure service reviews. These mechanisms have already led to reductions, deletions, and bundling where appropriate.

Moreover, CMS' assumption that clinicians automatically become more efficient with experience ignores how services are actually valued. When procedures are surveyed for valuation, most respondents typically experienced providers, meaning efficiency gains are reflected in the data. In addition, CPT Category I codes must demonstrate proven efficacy through published literature, ensuring they reflect established practice.

By sidestepping the RUC process, the proposed efficiency adjustment undermines both the relativity and credibility of the MPFS. Systematically reducing work RVUs and intraservice time across thousands of services—while exempting others—creates rank-order anomalies within the RBRVS. This not only disrupts internal relativity but also destabilizes other payment systems that rely on MPFS-derived RVUs for their own ratesetting.

Flawed Methodology

The proposed 2.5% adjustment is based on the prior five years of Medicare Economic Index (MEI) productivity adjustments. However, CMS does not disclose the precise sources of the year-to-year productivity figures, nor is it clear whether the efficiency adjustment would fluctuate annually with changes in the MEI adjustment. ASHA is also concerned that clinicians paid under the MPFS do not receive annual MEI inflation updates (unlike facilities), making it inequitable to use MEI as a justification for additional payment cuts.

Applying this adjustment every three years risks creating arbitrary, compounding reductions disconnected from actual practice realities. Efficiency gains have natural limits. Once services approach maximum efficiency, additional reductions are neither realistic nor safe. CMS' methodology risks creating a "ratchet effect", where cuts continue despite the absence of further gains. This dynamic could pressure providers to shorten patient interactions, increase error risk, and compromise quality of care.

If CMS finalizes this policy, it should clarify whether the adjustment will fluctuate annually with changes in the MEI and explain how it will evaluate and mitigate the potential ratchet effect.

Valuation for Remote Therapeutic Monitoring (RTM)

In September 2024, the CPT Editorial Panel added three new remote therapeutic monitoring (RTM) device supply codes to report respiratory, musculoskeletal, and cognitive behavioral therapy furnished for 2–15 days or 16–30 days within a 30-day period. The Panel also created one new code and revised existing codes to report RTM treatment management services for the first 10 minutes, the first 20 minutes, and each additional 20 minutes thereafter, along with updates to the remote monitoring guidelines.

ASHA appreciates CMS' proposal to recognize and adopt these new and revised RTM codes. However, we are concerned that CMS declines to adopt the RUC's recommended RVUs and instead assigns substantially lower values. This decision undermines the rigor of the code valuation process, disregards specialty society expertise, and results in inappropriate undervaluation of RTM services. By doing so, CMS jeopardizes Medicare beneficiaries' access to timely, patient-centered care that RTM is uniquely positioned to deliver—particularly for patients who benefit from continuous support in managing chronic and complex conditions.

Specifically:

- **CPT code 98XX7:** CMS rejects the RUC's recommendation of 0.66 work RVUs, proposing only 0.31, while applying the same flawed time ratio to determine clinical labor inputs.
- **CPT code 98980:** CMS rejects the recommended increase to 0.78 work RVUs and maintains the outdated value of 0.62.
- **CPT code 98981:** CMS proposes to retain the current 0.61 value, opposing the recommended 0.70.
- **CPT codes 98XX6 and 98978:** CMS disregards the RUC HCPAC practice expense recommendations, opting to contractor price the codes despite specialty societies who identified appropriate supply inputs and pricing.
- **Practice expense inputs:** CMS proposes to use OPPS cost data for several RPM and RTM codes. As ASHA has previously noted, OPPS data reflects hospital-based facility costs and cannot be appropriately applied to services under the MPFS, which are built

> on a resource-based methodology that accounts for professional work, practice expense, and malpractice costs in outpatient and community-based settings.

The RUC process is specifically designed to ensure that RVUs reflect real-world clinical work and expenses across diverse practice environments. Specialty societies contribute critical expertise, capturing data that cannot be replicated through reliance on OPPS data or contractor pricing. Rejecting these recommendations not only undervalues the professional time and resources required to provide RTM but also destabilizes relativity across the MPFS, as other codes remain appropriately valued through the established RUC process.

ASHA strongly urges CMS to adopt the RUC-recommended values for the new RTM codes. These values accurately capture the work, time, and resources necessary to provide high-quality RTM services and preserve patient access. Failure to do so risks undervaluing these services, disincentivizing provider adoption, and ultimately limiting the availability of care for patients who most need remote monitoring and management.

II.M. Determination of Malpractice (MP) Relative Value Units (RVUs)

For CY 2026, CMS does not propose major methodological refinements to the development of malpractice (MP) RVUs. Instead, CMS proposes to calculate MP RVUs using the most current malpractice insurance premium data available as of December 31, 2023, collected from the largest market-share insurers in each state. While ASHA appreciates CMS' use of current data, our analysis of the proposed 2026 MP RVU assignments for audiology and speech-language pathology services reveals significant reductions. Specifically, many codes with a global period indicator of ZZZ would see their already minimal MP RVUs decrease from 0.01 to 0.00, while some XXX codes are also reduced. These changes could further lower total RVUs for these services, resulting in unwarranted payment cuts for audiologists and SLPs.

ASHA recognizes that malpractice premiums may be lower for certain professions. However, reducing MP RVUs to zero undervalues the professional liability risks that exist for all providers and further destabilizes payment accuracy. The current methodology disproportionately benefits some specialties while imposing reductions on others—producing inequitable and unsustainable results. Importantly, eliminating MP values entirely for certain codes suggests—incorrectly—that those specialties carry no liability risk, which could have unintended downstream effects on both policy and perception.

To avoid these inequities, **ASHA respectfully requests that CMS reconsider its proposed methodology and establish a minimum floor for MP RVUs for specialties where malpractice premiums are significantly lower**. Setting a floor will ensure that all specialties are recognized as carrying at least some degree of liability risk while preventing further erosion of payment for audiologists and SLPs.

II.N. Geographic Practice Cost Indices (GPCIs)

CMS proposes to update Geographic Practice Cost Indices (GPCIs) beginning in CY 2026 but would continue using the 2006-based MEI cost share weights to determine the proposed practice expense (PE) GPCI values. Specifically, CMS would use these weights to measure the four components of the PE GPCI: employee compensation, office rent, purchased services, and medical equipment, supplies, and other miscellaneous expenses.

While CMS states that maintaining the 2006-based MEI cost share weights ensures consistency in the data used to update both the GPCI and MPFS ratesetting inputs for CY 2026, ASHA is deeply concerned that relying on data nearly 20 years old significantly misrepresents current practice costs. Office rent, staff wages, and other expenses have increased dramatically since 2006. Continuing to base payments on outdated input risks widening the gap between actual costs and Medicare reimbursement, threatening the financial sustainability of providers and ultimately patient access to care. Instead, CMS should incorporate more recent data sources—such as the 2017-based MEI cost shares—to ensure that GPCIs more accurately reflect today's practice environment.

In addition, the temporary 1.0 work GPCI floor will expire on September 30, 2025, unless Congress acts. Without an extension, clinicians in certain localities will face abrupt payment reductions that further destabilize practice finances and jeopardize patient access. **ASHA urges CMS to work with Congress to extend the 1.0 work GPCI floor to ensure more equitable payment across regions and to preserve patient access to essential audiology and speech-language pathology services.**

III.F. Medicare Shared Savings Program (MSSP)

Health Equity Benchmark Adjustment

ASHA opposes CMS' proposal to remove the health equity benchmark adjustment (HEBA) applied to quality scores beginning in fiscal year 2027. We supported the adoption of the HEBA because it incentivizes providers to care for patients with dual-eligible status by applying an upward adjustment to an accountable care organization's (ACO's) historical benchmark. This policy addressed a well-documented unintended consequence of many quality reporting and value-based care arrangements—namely, cherry-picking and lemon-dropping.

Cherry-picking refers to a practice used by some providers to reduce their financial risk, but it has the harmful consequence of jeopardizing access to care for sicker patients deemed "risky." In this approach, a provider selectively builds a caseload of patients without social risk factors—such as low income or education—who are generally healthy and medically uncomplicated. These patients are more likely to achieve favorable outcomes with minimal intervention. As a result, providers face a perverse incentive to maximize their quality scores and financial rewards by treating only the "ideal" candidates, rather than those with greater medical and social needs.

Lemon-dropping is the reverse. Patients with chronic conditions, multiple comorbidities, disabilities, or those in underserved populations or communities with less access to preventive care often require more intensive services, which increases the overall cost of care. Without a HEBA, providers may see their quality scores unfairly reduced when caring for these higher-need patients, creating an incentive to avoid them in order to maintain stronger scores and lower costs. As a result, some of the most vulnerable patients risk being dropped by providers and may face serious challenges in accessing necessary care.

ASHA continues to support applying the HEBA based on the number of beneficiaries an ACO serves who are dually eligible or enrolled in the Medicare Part D Low-Income Subsidy (LIS). The HEBA protects complex patients with a high prevalence of health-related social needs and ensures equitable access to care. **For these reasons, ASHA strongly urges CMS to not finalize its proposal to remove the HEBA and instead maintain this important adjustment within the MSSP.**

APM Performance Pathway (APP) Plus Quality Measure Set

CMS proposes to update the APM Performance Pathway (APP) Plus Quality Measure Set by removing Measure 487: Screening for Social Drivers of Health, a measure associated with social determinants of health (SDOH). CMS has also proposed to remove SDOH measures across the various payment systems it maintains—including home health, inpatient rehabilitation, and skilled nursing—for services provided in 2026. ASHA is concerned that removing these measures, particularly in combination with eliminating the HEBA, would reverse progress toward addressing social barriers to care, compromise quality, and ultimately increase Medicare costs.

ASHA supports including SDOH data elements in quality and payment systems because they gather critical information on patient demographics and the nonmedical factors that impact access to and the cost and quality of care. Research and evidence clearly demonstrate that SDOH—such as where people are born, live, learn, work, play, worship, and age—affect a wide range of health, functioning, and quality of life outcomes and risks. Timely and accurate identification, documentation, and treatment of such factors is essential for accessible, high-quality, holistic, patient-centered care that is effective and efficient.

Maintaining SDOH assessment items in the APP Plus Quality Measure Set aligns with CMS' goal of transitioning nearly all Medicare and Medicaid beneficiaries into accountable care relationships by 2030. Early and holistic identification and treatment of upstream factors is necessary to improve downstream outcomes and reduce costs. Such data codify factors that have significant impact on both the cost and outcomes of medical interventions. Removing these measures risks overlooking significant factors impacting beneficiary health.

MSSP Eligibility

ASHA also appreciates the proposal to adjust the eligibility requirements for the MSSP in order to lower barriers to entry for new ACOs. Under the proposed change, ACOs applying to enter a new agreement period on or after January 1, 2027, must have at least 5,000 assigned beneficiaries in benchmark year (BY) three. They would be allowed to have fewer than 5,000 assigned beneficiaries in BY one, BY two, or both.

This represents a change from previous policy that required an ACO to have at least 5,000 assigned Medicare FFS beneficiaries that are historically assigned to the ACO participants in each of the three historical benchmark years as defined in regulations. **ASHA supports the proposed flexibility, as it will lower barriers to entry for new ACOs to participate in the program.**

MSSP Extreme and Uncontrollable Circumstances Policies

ASHA supports CMS' proposal to expand the Extreme and Uncontrollable Circumstances Policies—used to determine exceptions to ACO quality and financial performance requirements—to include cyberattacks, in addition to natural disasters and public health emergencies. This change recognizes the broadened scope of potential threats as the use of electronic health records and reporting continues to grow.

ACO Participant Change of Ownership (CHOW)

Finally, ASHA supports the provision requiring ACOs to report certain participant list changes during the performance year—for example, when an ACO participant undergoes a change of ownership—as well as updates to the ACO's Skilled Nursing Facility (SNF) affiliate list, such as when an SNF affiliate experiences a change of ownership. Timely reporting of mid-year changes improves transparency and program integrity. It also supports beneficiary choice and care coordination by ensuring clear, current information makes it easier to identify who is responsible for a patient's care at any given time.

IV. Updates to the Quality Payment Program and Medicare Promoting Interoperability Program

Merit-Based Incentive Payment System (MIPS) Quality Performance Category

ASHA opposes the removal of following two existing quality measures for the 2026 performance (impacting 2028 payment adjustments),

- **#487: Screening for Social Drivers of Health:** Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
- **#498: Connection to Community Service Provider:** Percent of patients 18 years or older who screen positive for one or more of the following health related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least one of their HRSNs within 60 days after screening.

As outlined above, ASHA opposes the removal of these SDOH data elements, which gather critical information. We maintain that the systematic collection of detailed data on patient demographics and SDOH is essential for conducting accurate analyses of health care cost, access, and outcomes, thereby advancing the quality of care delivered to all Medicare beneficiaries. The identification, documentation, and strategic intervention on these factors are essential for delivering accessible, high-quality, and cost-effective care. In line with the CMS' objective to transition most Medicare and Medicaid beneficiaries into accountable care relationships by 2030, ASHA underscores the imperative of preserving SDOH-related assessment items within the APM Performance Pathway (APP) Plus Quality Measure Set to ensure equitable access to care and meaningful health outcomes.

MIPS Improvement Activities Performance Category

ASHA was pleased to see CMS propose two new improvement activities for the 2026 performance year of MIPS:

- Improving Detection of Cognitive Impairment in Primary Care
- Integrating Oral Health Care in Primary Care

Improving Detection of Cognitive Impairment in Primary Care

SLPs play a critical role in assessing, diagnosing, and treating cognitive-communication disorders, focusing on areas like memory, attention, executive functions, and problem-solving that impact communication and daily functioning. They assess cognitive abilities and their impact on communication, educate patients and caregivers, and collaborate with

interdisciplinary teams—using functional outcome measures—to develop personalized treatment plans for conditions such as traumatic brain injury, stroke, and dementia.

Therefore, ASHA recommends adding the following under the cognitive impairment activity description: *"Referral to an appropriate professional to assess and treat cognitive impairment for improved functional outcomes."* This addition would reduce the risk of under-identification or delayed treatment of cognitive impairments, support interdisciplinary collaboration, and ultimately improve patient outcomes in conditions such as traumatic brain injury, stroke, and dementia, where cognitive-communication interventions are essential to maximizing recovery and quality of life. (See **Evaluating and Treating Communication and Cognitive Disorders: Approaches to Referral and Collaboration for Speech-Language Pathology and Clinical Neuropsychology** for additional information).[3]

Integrating Oral Health Care in Primary Care

SLPs are also highly trained in recognizing and managing oral health-related issues due to their expertise in swallowing, feeding, and communication. They assess oral motor function, identify oral and craniofacial abnormalities, and provide education on oral health.

Therefore, ASHA recommends including SLPs in the required referral network for patients whose oral health could affect communication and swallowing. Because oral health is directly tied to safe swallowing, nutrition, and speech, SLPs are uniquely positioned to identify issues early, provide targeted interventions, and connect patients to appropriate care. Including SLPs ensures timely referrals, strengthens care coordination, and expands access for populations who already face barriers to dental services—ultimately improving health outcomes and reducing long-term system costs.

MIPS Value Pathways

ASHA acknowledges CMS' goal of transitioning from MIPS to MIPS Value Pathways (MVPs) by 2030. The proposed new MVPs related to diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery demonstrate the agency's commitment to advancing that transition. However, the current MVP structure does not allow for meaningful participation by many nonphysician qualified health care providers (QHPs), including audiologists and SLPs.

A central barrier is that MVPs require cost measure reporting, even though no such measures currently exist for nonphysician QHPs—despite years of active engagement by ASHA members in CMS' technical expert panels (TEPs). ASHA reiterates its request that CMS delay full transition to MVPs unless modifications or flexibilities are introduced to enable nonphysicians to participate effectively—or until TEPs develop cost measures inclusive of nonphysician services. Without such changes, nonphysician QHPs are effectively excluded from value-based programs through no fault of their own. This exclusion undermines the broader goals of MVPs by disregarding the critical contributions of audiologists and SLPs, who improve patient outcomes in areas such as communication, cognition, swallowing, and hearing.

Moreover, value-based models like MVPs rarely reflect the clinical value that nonphysician QHPs bring to interdisciplinary teams. When nonphysician QHPs are included, the incentive structures are almost always physician-centered, providing few opportunities for nonphysician participants to benefit from bonus payments. This not only limits engagement but also perpetuates inequities across the health care workforce.

Given these challenges, ASHA strongly recommends that CMS either relax MVP requirements when no cost measure exists for a specialty or maintain the traditional MIPS pathway to ensure all clinicians paid under the fee schedule have a viable means of participating and receiving annual payment updates. These changes are critical to ensure that audiologists, SLPs, and other nonphysician providers are recognized, valued, and meaningfully included in the future of value-based care.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

ASHA supports CMS' proposal to adopt a web-mail-phone protocol for the CAHPS for MIPS Survey beginning with performance year 2027 and discontinue the mail-phone protocol. Adding a web option modernizes the survey process and is likely to improve response rates by making participation more convenient and accessible. Higher response rates translate into more complete and representative patient feedback, strengthening the reliability of the data used for quality measurement. A web option also reduces administrative burden and mailing costs over time, making the process more efficient for both providers and CMS. Ensuring robust and representative patient input is critical to evaluating performance accurately, promoting transparency, and supporting value-based care goals.

Well-Being and Nutrition Measures Request for Information (RFI)

Well-Being

As the U.S. population ages and chronic disease burdens grow, strengthening social connections and psychological well-being—including purpose, optimism, and social support—offers a promising, evidence-based strategy to prevent disease and promote resilience in older adults.[4] Research suggests that quality of life in older adults depends not only on health status but also on social connections, which may be as equally valued as health status.[5]

Communication disorders can sever these essential links from patients to their community and natural environment. These conditions vary in type, severity, and co-occurrence with other symptoms that limit mobility, vision, endurance, or cognition.[6] Audiologists and SLPs specialize in the prevention, screening, diagnosis, and treatment (including caregiver training) of communication disorders. Early access to hearing and communication services improves a patient's ability to share and receive essential health information and to maintain the social connections that are vital to their well-being as they age.

ASHA underscores the vital importance of comprehensive functional outcome measures to accurately capture a patient's full range of functional status including hearing, swallowing, communication, and cognitive function—all of which promote a patient's overall well-being. Failure to capture holistic functional outcomes leaves beneficiaries vulnerable to myriad health risks and avoidable increased costs to Medicare. Accurately measuring these functional domains will capture potential hinderances to social interaction and its downstream effects on well-being. The existing cross-setting discharge function measure used by SNFs, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals could serve as a starting point for such measures and be expanded to outpatient settings.

We remain committed to assisting CMS and providers to address all domains of function to include measures complementing the existing cross-setting discharge function measure.

Nutrition

The speech-language pathology scope of practice encompasses assessment, management, and treatment of swallowing and feeding disorders, which can impact a patient's nutritional status. SLPs are the primary providers for swallowing and feeding services, and their role includes identifying signs and symptoms of swallowing problems, evaluating swallow function, and providing treatment to improve swallowing ability. SLPs also often work with patients who are tube fed to help them transition to oral intake. Treatment for feeding and swallowing disorders has been shown to be cost effective with potential cost savings of $54,000 per patient through a reduction in the cost of alternative feeding strategies, such as tube feeding, and prevention of adverse events, such as aspiration pneumonia. [7,8]

Therefore, we encourage CMS to consider ASHA's Functional Communication Measures (FCMs) for swallowing—developed as part of our National Outcomes Measurement System (NOMS)—as the basis for a measure of swallowing skills for oral nutrition. ASHA stands ready to partner with CMS to explore the use of swallowing-specific FCMs and other potential measures to ensure beneficiaries with swallowing and feeding disorders receive adequate nutrition and hydration.

Thank you for considering ASHA's comments. If you have 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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