June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1833-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), I am writing in response to the fiscal year (FY) 2026 inpatient prospective payment system (IPPS) 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 work in acute and long-term care hospitals (LTCHs) and are integral members of multidisciplinary care teams dedicated to the quality and outcomes of care patients receive.

Hospital Inpatient Quality Reporting (IQR) Program

ASHA opposes the Centers for Medicare & Medicaid Services' (CMS) proposal to remove the following quality measures:

- Hospital Commitment to Health Equity beginning with the CY 2024 reporting period/FY 2026 payment determination
- Both the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures, beginning with the CY 2024 reporting period/FY 2026 payment determination.

We firmly believe that effective communication is a human right, accessible and achievable for all. A commitment to health equity that addresses Social Determinants of Health (SDOH) helps hospitals monitor, identify patterns with, and improve care gaps that impact different populations—including those with communication disorders—differently. As of 2016, an estimated one in four—or 61 million—adults in the United States reported a disability. People with disabilities (such as mobility limitations, deafness and blindness, or intellectual disabilities) face many challenges to achieving optimal health and accessing high-quality

health care.[1] Health equity protects people with disabilities by incentivizing high-quality health care for all people. Therefore, ASHA recommends CMS maintain these measures in the IQR program.

Hospital Value-Based Purchasing (VBP) Program

ASHA opposes the removal of the Health Equity Adjustment from the Hospital VBP Program's scoring methodology beginning with the FY 2026 payment determination. This adjustment was created to incentivize hospitals serving higher proportions of dual-eligible patients (both Medicare and Medicaid) by awarding them additional points in the Total Performance Score (TPS).

As noted earlier in these comments, ASHA firmly believes that effective communication is a human right, accessible and achievable for all. The Health Equity Adjustment helps facilities monitor, identify patterns, and improve care gaps that impact different populations—including those with communication disorders—differently. Given that 25% of U.S. adults have reported a disability, understanding and addressing the challenges these individuals face to ensure they receive high-quality health care is critically important. Therefore, ASHA encourages CMS to maintain the health equity adjustment and not finalize its proposal.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

ASHA opposes the proposed removal of the four standardized patient assessment data elements: one item for Living Situation, two items for Food, and one item for Utilities.

SDOH—or the nonmedical factors such as where people are born, live, learn, work, play, worship, and age—affect a wide range of health, level of functioning, and quality-of-life outcomes and risks. The identification, documentation, and intervention of such factors is essential for high-quality, holistic, patient-centered care. Attention to such factors can facilitate upstream interventions to prevent downstream costs in line with the Administration's Make America Healthy Again initiative.

We support the practice of early and holistic identification and intervention for such factors to improve health outcomes and reduce the overall cost to the health system. Audiologists and SLPs are strongly positioned through frequency of patient contact, strong rapport, practice in a variety of settings, and specialization in communication to obtain essential SDOH information that patients may be reluctant to share.[2]

Aside from their clinical characteristics, nonmedical factors and forces in someone's daily life can also significantly affect their health outcomes. These SDOH can include health care access and quality, education access and quality, economic stability, social and community context, and neighborhood and built environment.

Patients with similar health care concerns can have very different circumstances. Consider two patients, both of whom have sustained a stroke and have aphasia and right-sided weakness. Patient A lives alone in a small house in a rural community. They don't drive, and the closest outpatient clinic is 45 minutes away. They often wait until the first of the month to purchase food and medicine, and they struggle to keep up with household chores. Patient B

has a suite of rooms to themselves in their adult child's home located in a gated suburban community. The family has hired a part-time caregiver who helps Patient B with personal care, cooks their meals in the suite's fully stocked kitchenette, picks up their prescriptions, and fills their daily medication box. The patient's child or spouse drives them to follow-up outpatient appointments at the clinic five minutes away.

Which of these patients is more likely to earn the provider an incentive payment for achieving positive outcomes and lowering costs? Despite their similar clinical characteristics, Patient B is more attractive to a provider, as they will likely have better outcomes and require fewer services.

Payment systems that incentivize providers to achieve better outcomes at the lowest cost cannot be considered value based. Value can only be achieved when nonmedical factors inform the cost and outcomes of care.[3]

Changes to the Transforming Episode Accountability Model (TEAM)

The Transforming Episode Accountability Model (TEAM) is an episode-based, alternative payment model in which selected acute care hospitals will coordinate care for people with traditional Medicare undergoing lower extremity joint replacements, surgical hip femur fracture treatments, spinal fusions, coronary artery bypass grafts, or major bowel procedures. The acute care hospital assumes responsibility for the cost and quality of care from surgery through the first 30 days after the Medicare beneficiary leaves the hospital.

Audiologists and SLPs can serve as valuable members of such teams. Audiologists specialize in preventing and evaluating hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Timely identification of a balance disorder could prevent falls or other injuries, which could prevent fractures requiring surgery. After surgery, SLPs play a vital role in evaluating, treating, and rehabilitating patients with communication, swallowing, and cognitive impairments. This includes helping patients regain speech and language skills, manage swallowing difficulties, and address any cognitive deficits that may have arisen due to the surgery.

Additionally, as communication sciences experts, audiologists and SLPs play a critical role in ensuring communication challenges do not get in the way of improving the quality and outcomes of care regardless of the patient's diagnosis. Health care professionals outside of audiology and speech-language pathology, who likely receive little training in the area of communication, may not recognize or be familiar with hearing loss, mild cognitive impairment, aphasia from a past stroke, residual effects of cardiac events, use of augmentative and alternative communication (AAC), stuttering, articulation disorders, and other communication difficulties.

Without this knowledge and understanding, nurses, doctors, front-office staff, and allied health professionals may not be able to communicate effectively with their patients—thus compromising the quality of care at a time when quality is set to become the major focus of health care payment. Care provided without first establishing communication access can result in higher rates of hospital readmissions, higher total cost of care, reduced patient safety, reduced compliance, and low patient satisfaction.[4,5,6,7,8] Effective incorporation of

audiologists and SLPs will help all TEAM stakeholders—including clinicians, CMS, and patients—achieve the intended outcomes of this important initiative.

ASHA looks forward to engaging with CMS to explore additional ways to meaningfully integrate nonphysician qualified health providers, such as audiologists and SLPs, into future value-based care models.

Thank you for your consideration of our comments. If you have any questions, please contact Rebecca Bowen, CCC-SLP, ASHA's director for health care policy for value and innovation, at rbowen@asha.org or 301-296-8742.

Sincerely,

A. B. Mayfield-Clarke, PhD, CCC-SLP
2025 ASHA President

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