June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1827–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), I am writing in response to the fiscal year (FY) 2026 skilled nursing facility prospective payment system (SNF PPS) 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 SNFs and are integral members of multidisciplinary care teams dedicated to the quality and outcomes of care patients receive.

SNF Value-Based Purchasing (VBP) Program

ASHA opposes the removal of the VBP program's Health Equity Adjustment. We firmly believe that effective communication is a human right, accessible and achievable for all. The Health Equity Adjustment helps SNFs 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.

SNF Quality Reporting Program (QRP)

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

Social Determinants of Health (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 clinical characteristics, nonmedical factors and forces in someone's daily life can also significantly affect their health outcomes. These 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 themself 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]

RFI on Future Measure Topics: Nutrition

The speech-language pathology scope of practice encompasses assessment, management, and treatment of swallowing and feeding disorders, including dysphagia. SLPs are considered 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 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.[4,5]

ASHA has developed a Functional Communication Measures (FCMs) scale specific to swallowing as part of our National Outcomes Measurement System (NOMS) that could

serve as a measure of swallowing skills for oral nutrition.[6] ASHA looks forward to partnering with the Centers for Medicare & Medicaid Services (CMS) to explore this and/or other measures related to adequate nutrition and hydration in patients with feeding and swallowing disorders.

RFI on Future Measure Topics: Delirium

SLPs serve as members of interdisciplinary teams to prevent and manage delirium. In addition, they provide rehabilitation for cognitive communication deficits that may persist after delirium has resolved. CMS could consider the use of nonpharmacological treatments for delirium (e.g., caregiver training) to capture the impact of speech-language pathology intervention for patients with delirium. High-quality delirium severity measures used by SLPs such as Confusion Assessment Method, Confusional State Examination, Delirium-O-Meter, Delirium Observation Scale, Delirium Rating Scale, and Memorial Delirium Assessment Scale can be used to gauge prognosis, monitor response to treatment, and estimate burden of care both during and after hospitalization.[7]

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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