June 9, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1849-P
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), we write in response to the fiscal year (FY) 2027 inpatient prospective payment system (IPPS) proposed rule.

ASHA is the national professional, scientific, and credentialing association for 247,000 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.

Mandatory Models: CJR-X and Transforming Episode Accountability Model (TEAM)

While we appreciate CMS' efforts to expand the reach of value-based models, we believe that mandatory participation presents significant challenges, particularly for hospitals that lack the scale or financial capacity to make the necessary investments in care redesign. A phased or voluntary approach would better support success, allowing organizations to build the infrastructure and partnerships needed to achieve shared savings and improved outcomes.

CJR-X

In its FY 2027 IPPS proposed rule, CMS introduced a proposed expansion of its Comprehensive Joint Replacement (CJR) Model, termed CJR-X. Generally, ASHA appreciates that CMS has continued interest in reducing and controlling costs and improving clinical outcomes. However, we have considerable concerns that the model's proposed structure does not adequately capture or emphasize downstream services required for patients to achieve optimal recovery and prevent secondary complications. Patient health and recovery are inextricably tied to additional, nonphysician pre- and post-operative care. Without appropriate therapy, the value of other interventions diminishes.

CMS proposes that "an LEJR episode would begin when a beneficiary is admitted for an anchor hospitalization for one of the following MS-DRGs or an anchor procedure" and that "the episode start date would be the day of the anchor procedure for outpatient procedures and the date of admission for an inpatient hospitalization," respectively.[1] ASHA agrees that it would be

appropriate to use these dates to help define the episode, but, as proposed, it does not clearly capture the use of prehabilitation. Prehabilitation includes any rehabilitative care visits provided prior to (and in connection with) the anchor surgery, though the duration, scope, and frequency of these visits vary.

ASHA recommends expanding the episode to include therapy interventions within the weeks prior to (and in connection with) the anchor surgery and urges CMS to determine how it can collect data on the intensity, timing, and duration of prehabilitation care.

Similarly, although a 90-day episode may be sufficient to assess the immediate success and cost of *surgery*, it does not fully capture the success of the patient's *recovery*, which often extends well beyond that timeframe. ASHA urges CMS to consider monitoring functional recovery after the 90-day episode ends, ideally up to one year from the surgery. ASHA understands that CMS may not practically be able to extend the cost-based elements of the model to this extended period, but collecting post-episode patient data could still provide valuable insight into the patient recovery process and downstream utilization of services.

Ninety days following the anchor surgery, patients are often expected to continue an existing rehabilitation regimen on their own. Yet adherence and quality of life may decline substantially once formal in-person therapy stops. A patient's surgery may appear successful at 30, 60, or 90 days, but none of those timelines reflect whether the patient achieves sustained, long-term improvement. Setbacks following the 90-day episode carry their own costs that should be considered.

It would therefore be prudent for CMS to examine beneficiaries' outcomes after the episode concludes, specifically focusing on secondary risk factors that may affect recovery over time.

Finally, CMS should include a telehealth waiver for CJR-X. Access to telehealth promotes flexibility and early and timely attention to any issues a patient is experiencing in their rehabilitative process. This waiver was used often and appropriately during the CJR model, and we believe the same flexibility would be appropriate for CJR-X.[2]

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.

In addition, 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.[3,4,5,6,7] Effective incorporation of audiologists and SLPs will help all TEAM stakeholders—including clinicians, CMS, and patients—achieve the intended outcomes of this important initiative.

Hospital Value-Based Purchasing (VBP) Program

Existing dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems survey include:

- Communication with nurses;
- Communication with doctors; and
- Communication about medicines.

The inclusion of SLPs in all applicable episodes ensures that communication access is established, thus improving the fidelity of such measures to capture comprehensive health care quality.

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:

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Submitted on behalf of the American Speech-Language-Hearing Association

[1] Centers for Medicare & Medicaid Services. (2026, April 14). Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes. *Federal Register, 91*(71), 19312. https://www.federalregister.gov/documents/2026/04/14/2026-07203/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-ipps-and#p-2933

[2] The Lewin Group, Inc. (April 2023). *CMS Comprehensive Care for Joint Replacement Model: Performance Year 5 Evaluation Report: Fifth Annual Report*. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-annual-report

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