ASHA
American
Speech-Language-Hearing
Association

August 20, 2026

Sylvia Fogel, MD
Chair, Interagency Autism Coordinating Committee
U.S. Department of Health and Human Services
6001 Executive Boulevard
Rockville, MD 20852

Re: Comments on the IACC Strategic Plan, 2026–2028 (July 17, 2026, Working Draft)

Dear Dr. Fogel:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to express our thoughts on the working draft of the IACC Strategic Plan 2026–2028.[1]

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.

Our members serve millions of children and adults with communication disorders—including those with a diagnosis of autism—across our nation's schools, hospitals, clinics, and other settings. Our members also serve a substantial number of children with disabilities who receive services under various programs ranging from the Individuals with Disabilities Education Act (IDEA) to Medicaid and Medicare. Audiologists specialize in preventing, assessing, and treating hearing and balance disorders. SLPs identify, assess, and treat speech, language, swallowing, and cognitive communication disorders. The services ASHA members provide are medically necessary, evidence-based, and essential to health and independence across the lifespan.[2]

Thank you for the opportunity to comment on the Interagency Autism Coordinating Committee's (IACC) strategic plan. ASHA has reviewed the full working draft and offers the comments below specifically as they intersect with the scopes of practice of audiology and speech-language pathology in clinical and school-based settings, focused primarily on 1) Concerns Regarding Text-Based and Letter-Based Communication Approaches; 2) Augmentative and Alternative Communication (AAC), IDEA, AI, and Literacy; 3) Role of Audiology; and 4) Importance of a Continuum of Support From Early Intervention Through Medicare.

I. Positive Aspects of the Draft Plan

ASHA welcomes the working draft's recognition of the centrality of communication to access a range of supports, including academic, functional, employment, and mental health. ASHA also supports the plan's repeated calls for expanded federal research funding across the full range of AAC modalities, ranging from comparative effectiveness to precision-health research aimed at identifying which communication approaches work best for different

individuals. Rigorous, well-funded research is exactly what is needed to narrow the evidence gaps and improve individual outcomes.

ASHA further welcomes the working draft's explicit recognition that shortages of SLPs and other related-services personnel contribute to delayed evaluations and missed IDEA services. The draft's proposal to extend personnel-preparation grants and loan forgiveness to SLPs is an important step toward addressing these shortages. ASHA also supports the working draft recommendation that states should be encouraged to develop supplemental measures of growth for students. This could include progress with functional skills such as communication that directly impacts life experiences from school age through adulthood.

The Committee acknowledges that individualized home- or community-based services offer people care where they can enjoy independence. ASHA members provide individualized and family-centered care in many settings—including schools, health care facilities, the community, and at home—to improve the quality of life of individuals with autism. The draft acknowledges the need to fund staff salary, training, community programs, and research aligning with the efforts of ASHA members.

II. Concerns Regarding Text-Based and Letter-Based Communication Approaches

ASHA is concerned that "Life Course Domain III: Improving Communication and Access for Nonspeaking and Minimally Speaking Autistic Individuals," while never naming Facilitated Communication (FC), the Rapid Prompting Method (RPM), or Spelling to Communicate (S2C), describes and would extend federal protection to a category of practice that matches those methods' defining features. The working draft states that "text-based and letter-based communication approaches are used by a substantial and growing number of nonspeaking individuals." It further notes that "these methods typically involve a trained communication partner—a person, often a parent, aide, educator, or clinician, who supports another individual's communication." This is the standard descriptive framing for FC, RPM, and S2C, in which a facilitator physically, proximally, or emotionally supports and, in practice, may influence a person's selection of letters or words.

Notably, the working draft's own reference list, under the heading "Text-based and letter-based communication methods," cites ASHA's 2018 FC position statement alongside literature reflecting the ongoing scientific dispute over these methods' validity. The literature includes studies supportive of FC authorship and published critiques and rebuttals of that literature, as well as a systematic review of communication interventions for minimally verbal children with autism.

The body of the working draft, however, does not engage with this dispute or reflect the substance or conclusions of ASHA's position statement. ASHA's position is that the current scientific evidence does not support FC, RPM, or similar facilitator-dependent communication methods that do not verify authorship as valid means of establishing independent communication. Research has not demonstrated that messages generated through these methods can be reliably attributed to the individual rather than the facilitator or communication partner. ASHA supports access to effective communication services and supports that are individualized based on physical, cognitive, developmental, and social communication needs. Using methods that do not adequately verify authorship infringes

upon an individual's right to communicate with AAC that supports autonomous, self-generated expression.[3,4]

ASHA supports the use of letterboards and typing as one modality of communication, especially when:

- Members of the individual's care or education team provide them with explicit literacy instruction;
- Qualified professionals offer the individual an assistive technology or AAC evaluation that addresses their unique physical, intellectual, social, and personal needs; and
- The individual, communication partner, or supporting professionals can clearly verify authorship.

The working draft's operative language raises three specific concerns.

Concern 1: Reframing the Evidentiary Standard

Initiative 1 states that "federally funded or public programs should support continued access to communication methods when individualized, experience-based evidence suggests the method is effective for them, including while broader research is underway." Initiative 2 states that "access should not be delayed or restricted to methods with completed randomized trials."

The draft also states that the current absence of controlled-study evidence for text-based methods "should not be represented or considered equivalent to proof of ineffectiveness or evidence of invalidity." ASHA agrees that individualized clinical judgment and family preference are essential components of evidence-based practice, and that access to AAC should not be delayed pending research. However, for facilitator-dependent techniques specifically, the relevant controlled research already exists—most recently published in July 2026—and has failed to demonstrate that the facilitated individual, rather than the facilitator, is the author of the communication produced.[5]

Treating "individualized, experience-based evidence" as sufficient to establish a method's effectiveness, without qualification, risks validating techniques that controlled research has examined and found wanting on the question that matters most: authorship. The use of methods that lack a sufficient evidence base is not without risk. When children and families devote limited time to interventions that have not demonstrated meaningful outcomes, and public resources are used to support those interventions, those children and families may lose opportunities to access effective, evidence-based services. This can undermine the quality of services while increasing costs for families and publicly funded programs.

Concern 2: Barring Categorical Exclusion of Text-Based Methods, Including in Federally Funded Programs

Initiative 1 states that "Nonspeakers should not be categorically barred from using an AAC method, including but not limited to text-based methodologies, communication support, or communication partner arrangement in federally funded or public programs," and directs HHS' Office of Civil Rights to "issue effective-communication guidance" establishing this standard. Separately, the working draft directs CMS to "identify state policies that categorically exclude communication methods" and "issue guidance clarifying … that

Medicaid Home and Community-Based Services (HCBS) and self-directed budgets may not categorically exclude a method without an individualized, person-centered determination." Initiative 1 also states that "CMS should apply the same individualized standard in Medicaid."

ASHA recognizes that this framing stops short of mandating coverage of any specific method and states that it "does not require any federal agency to endorse a particular AAC method." Nonetheless, prohibiting categorical, method-based exclusions without carving out an exception for methods that lack scientific support for facilitated authorship would functionally bar states, schools, and clinicians from maintaining evidence-based policies against approaches like FC, RPM, or S2C and others where authorship is not verified. It could also place professionals or programs that decline to use or that publicly caution against these methods at odds with federal guidance and at risk with respect to funding eligibility.

These concerns are especially significant in health care settings, where communication may be used to establish informed consent, refusal of treatment, pain reporting, and participation in care and planning. ASHA strongly supports effective communication access across health care settings. However, federal guidance should not be interpreted to require hospitals, rehabilitation facilities, outpatient clinics, skilled nursing facilities or other health care entities to provide or accept facilitator-dependent communication methods in the same manner as qualified language interpreters or sign language interpreters when authorship cannot be independently verified.

Any communication support used for medical decision-making should include safeguards for patient safety, documentation, conflict of interest, privacy, and clear verification that communication reflects the individual's own intent. Federal guidance should distinguish evidence-based AAC access, communication partner training, and supported decision-making from methods that rely on facilitator influence or have unresolved authorship concerns.

Concern 3: Broadening Who May Conduct Communication Evaluations

Initiative 2 calls for "comprehensive, individualized communication evaluation conducted by qualified professionals (including but not limited to speech-language pathologists, occupational therapists, and special education teachers)." Throughout Domain III, speech-language pathology is consistently listed as one referral pathway among several rather than identified as the profession whose scope of practice, licensure, and clinical training specifically qualify it to lead comprehensive communication evaluation, including speech-generating device evaluations. The open-ended "including but not limited to" framing, combined with detailed guidance elsewhere in the working draft regarding assessment content, is concerning because this level of clinical and procedural specificity does not appear to reflect substantive input from SLPs—the professionals with primary responsibility for this work in clinical and school-based settings.

ASHA recommends that the final strategic plan: (1) explicitly outline the issues with facilitator-dependent, authorship-uncertain techniques such as FC, RPM, and S2C consistent with the existing controlled research on those specific techniques and with ASHA's position statement, which the working draft already cites; (2) reaffirm that AAC and

communication method selection should be grounded in the best available scientific evidence together with clinical judgment and individual preference, rather than framed as a choice between controlled research and individual experience; (3) specify that comprehensive communication and AAC evaluations be conducted or directly supervised by licensed, appropriately credentialed SLPs, with other professionals contributing as part of a team led by an SLP where communication is the primary area of concern; and (4) clarify that communication guidance for federally funded health care programs should promote evidence-based AAC access and supported communication while incorporating safeguards for authorship, informed consent, and patient safety.

ASHA urges the Committee to revise Domain III to ensure that communication access is expanded without compromising authorship, safety, or evidence-based practice.

III. Augmentative and Alternative Communication (AAC), IDEA, AI, and Literacy

ASHA agrees with the working draft's recognition that AAC needs vary widely and that access to a range of modalities should be individually determined, explicitly taught, and available at all times, including speech-generating devices, picture-based systems, eye-gaze, and other assistive technology. Consistent with ASHA's guidance on the roles of the SLP in school-based service delivery, ASHA's position is that SLPs hold primary responsibility for AAC assessment, system recommendation, implementation, and progress monitoring, in collaboration with audiologists, educators, and families.[6]

Students with speech, language, hearing, and communication disorders represent one of the largest disability populations served in public schools. Communication is foundational for all learning. Difficulties with language processing, phonological awareness, fluency, social communication, and hearing directly impact a student's ability to access the curriculum, engage with instruction, and demonstrate academic achievement.

Federal paperwork mandates and implementation silos reduce the time audiologists and SLPs can devote to providing direct, individually tailored services across the lifespan. It's vital to facilitate an appropriate federal-state relationship that supports families and children. Audiologists and SLPs should be free to "exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or prescription prevents keeping the welfare of persons served paramount."[7]

There are some federal requirements that could be clarified to ensure the Individualized Education Program (IEP) team and family ultimately make the educational, intervention, and assessment decisions for their students.

For instance, as it relates to the 1% cap under the Every Student Succeeds Act, the Department should make it clear that (1) IDEA is the controlling statute and (2) professional best judgment and the IEP team should have the final say on whether IDEA Part B students with the most significant cognitive disabilities are assessed using alternative academic achievement standards.

Furthermore, it is imperative to highlight the importance of greater coordination between IDEA and other programs that support IDEA's goals—for example, the Early Hearing

Detection & Intervention (EHDI) program in the Part C context and school-based Medicaid with Part B. Improved technical assistance explaining how federal funding can be braided, rather than siloed, with other sources of coverage—including commercial insurance—to support infants and toddlers would be a valuable resource for parents beginning to navigate the complex network of public and private supports available to autistic individuals.

Given the rise of artificial intelligence (AI) and the working draft's mention of AI "assisted communication tools," it would be helpful to highlight how this technological advancement can potentially support autistic individuals. With appropriate direction and oversight, AI has the possibility to help audiologists and SLPs generate personalized, developmentally appropriate materials such as speech sound word lists, hearing technology troubleshooting checklists, and AAC supports. Tools that analyze and deepen student interests could improve engagement toward educational and functional goals in alignment with IDEA.

AI could support the development of interest-driven tools for visual reinforcement audiometry or conditioned play audiometry, tailoring activities to provide person-centered care to increase patient engagement. AI-generated listening activities or environmental sound libraries could enhance hearing education and auditory training. This could include the intersection of AI with the broad continuum of assistive technology supports outlined through the Administration's current guidance.

Audiologists and SLPs are also exploring AI to reduce administrative burden, organize information, and improve workflow efficiency. School-based professionals are also considering how AI can support interprofessional team collaboration, documentation, and educational planning.

However, such tools must also comply with IDEA's requirement for individualized, measurable goals and evidence-based interventions. These tools must also not have bias embedded in their training data and must maintain privacy protections mandated by the Family Educational Rights and Privacy Act (FERPA). Federal investments should prioritize tools that are transparent, educator-controlled, and aligned with IDEA and professional practice guidelines.

Professionals such as audiologists and SLPs must retain full clinical judgment for documentation accuracy and should be involved in any procurement, design, and review of output process for AI documentation tools. As with any tool, the licensed provider should have the ultimate decision-making authority over the application of AI in audiology and speech-language pathology services. Keeping a human in the loop of any AI workflow is essential to ensure safety, transparency, compliance, and best practice.

Regarding literacy, ASHA recommends that the final strategic plan more fully address literacy development for autistic students generally. This would be consistent with ASHA's official position that SLPs' roles and responsibilities extend across the continuum of reading and writing development, including language comprehension, phonological awareness, and written language skills that underlie literacy for children and adolescents with a range of communication profiles—including those who use AAC.[8] SLPs are both specialized instructional personnel and related service providers in the context of delivering education services in early intervention and school-based settings.

IV. Role of Audiology

ASHA notes that the working draft does not substantively address audiology's role in autism screening, evaluation, or diagnosis anywhere in the document. This is a significant gap. Approximately 4% of children who are deaf or hard of hearing have co-occurring autism spectrum disorder. Several hallmark features of hearing loss—including inconsistent response to name, delayed language development, echolalia, and delayed social communication skills—closely resemble features of autism. This creates a substantial risk of diagnostic confusion in both directions.[9]

Children with permanent hearing loss and co-occurring autism are frequently diagnosed with autism later than their hearing peers, in part because overlapping features can obscure early identification. In one clinical sample, only 25% of children with dual diagnoses were identified with autism by age four, and roughly half were not identified until after age five and a half. Because autistic children may also demonstrate increased sensitivity to sound, and because hearing loss can be missed even after a child passes newborn hearing screening due to delayed onset or progressive hearing loss, a comprehensive audiologic evaluation is an essential (and too frequently omitted) component of a thorough autism diagnostic evaluation.

ASHA recommends that the final working draft explicitly identify audiologists, and comprehensive audiologic evaluation, as a recommended component to consider—particularly for children presenting with delayed language, auditory processing concerns, reduced responsiveness to name, or other communication-related concerns that could reflect an undiagnosed hearing loss rather than, or in addition to, autism.

V. Importance of a Continuum of Support From Early Intervention Through Medicare

ASHA welcomes efforts to address the needs of people with autism across the lifespan. Audiologists and SLPs work regularly to support programs ranging from services provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits in the Medicaid program and HCBS to school-based Medicaid and Medicare. It is vital that all of these systems are appropriately funded, and that coding, billing, and reimbursement is appropriate and adequate and facilitates the best care possible regardless of setting or one's stage of life.

We appreciate the emphasis on the goals of independent living and the academic, functional, and workforce support needed to maximize agency and choice that is person-centered. This includes services that support communication, feeding, and swallowing. It also includes mental health for all populations, including older adults who may need "access to aging services, adult and geriatric health care, Medicare-covered preventive care, dementia and cognitive-change recognition, long-term services and supports, communication access, supported decision-making, safety protections, palliative care…" supported by evidence-based research.

As the Committee considers communication access and supported decision-making across the lifespan, ASHA encourages the IACC to consider the operational realities of health care

settings. In inpatient rehabilitation, outpatient clinics, skilled nursing facilities, home health, and palliative care, communication modalities directly affect diagnosis, treatment planning, consent, refusal of care, safety reporting, discharge planning, and caregiver involvement. Health care systems need clear guidance that supports access to evidence-based AAC, evaluation from qualified SLPs, communication partner training, and person-centered supported decision-making, while also protecting patients from reliance on communication methods where authorship cannot be verified.

Federal implementation efforts should also recognize the workforce, reimbursement, and documentation infrastructure needed to make communication access meaningful in clinical care.

For instance, ensuring Medicare coverage of the services and supports these individuals need as they age and qualify for Medicare, by virtue of age or disability, will be important to ensure our common objectives for this population are achieved. Fortunately, the Medicare program has several elements that can be leveraged to maintain coverage for people with autism.

For example, Medicare covers speech-language pathology services either to improve or maintain function for the patient. This is particularly important because medically necessary interventions can be provided if they will help a person maintain a level of function or prevent further decline. As some people with autism may not “improve” beyond a baseline, it’s just as important to ensure they have the skills and compensatory strategies to function in their daily lives.

Quality and value-based care initiatives offer promise to ensure the quality and outcomes of care delivered to Medicare beneficiaries, including those with autism. For example, under the Merit-based Incentive Payment System (MIPS), measures exist to report suspected elder abuse. Those with intellectual disabilities are also susceptible to abuse or mistreatment, so application of such measures could be appropriate to protect a broad range of Medicare beneficiaries.

ASHA also encourages the Committee to further emphasize workforce capacity as a critical factor in ensuring access to services across the lifespan. Persistent shortages of audiologists, SLPs, and other specialized personnel can delay evaluation and intervention and limit access to evidence-based supports. Federal efforts to strengthen recruitment, preparation, retention, and workforce sustainability should be included as part of the long-term strategy to improve outcomes for autistic individuals.

Conclusion

ASHA appreciates the IACC’s effort to build a strategic plan that reflects the autonomy and full range of needs of autistic individuals across the lifespan and supports the working draft’s emphasis on communication access, research investment, and individualized services, as well as its recognition of the SLP workforce shortages affecting IDEA implementation.

ASHA respectfully urges the Committee to revise its framing of facilitator-dependent, authorship-uncertain communication techniques, to reaffirm an evidence-based practice

framework for communication intervention and to specify SLP leadership of comprehensive communication evaluation; to more fully address literacy development for autistic students broadly; and to add explicit recognition of audiology's role in comprehensive autism evaluation. Taken together, these recommendations would strengthen the strategic plan's alignment with evidence-based practice and help ensure that autistic individuals have access to safe, effective, individualized communication supports across the lifespan.

ASHA would welcome the opportunity to serve as a resource to the Committee as the working draft is finalized and would be pleased to provide additional research, clinical, or policy information on any of the topics addressed in this letter.

Thank you for the opportunity to provide these comments. If you or your staff have any questions, please contact Bill Knudsen, ASHA's director of education policy, at bknudsen@asha.org.

Sincerely,

Linda I. Rosa-Lugo, EdD, CCC-SLP
2026 ASHA President

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