



August 31, 2026

Dr. Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1844-P  
7500 Security Boulevard  
Baltimore, MD 21244-8013

RE: Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), we write in response to the calendar year (CY) 2027 home health prospective payment system (HH PPS) 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 audiologists and SLPs work in the home health sector where they are integral members of multidisciplinary care teams dedicated to the quality and outcomes of care patients receive.

ASHA appreciates CMS' ongoing efforts to strengthen the Medicare home health benefit and ensure that beneficiaries receive high-quality, patient-centered care. As CMS considers the policies outlined in the proposed rule, we encourage the agency to ensure that changes support access to medically necessary services, recognize meaningful functional outcomes and communication needs, and protect beneficiaries while avoiding unnecessary barriers to qualified providers. We offer the following comments and recommendations.

### **Section II.B.1 Routine PDGM Monitoring**

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Since implementation of the Patient Driven Groupings Model (PDGM), CMS data has shown a significant difference between the cost of care and payments to the home health sector. Specifically, payments to home health agencies have exceeded costs by at least 30% since 2020. This is likely in part due to a dramatic drop in therapy service provision.

Therefore, ASHA recommends that CMS continue to closely monitor therapy utilization under PDGM—including utilization by the specific therapy disciplines—to identify any changes that could indicate inappropriate reductions in access to medically necessary care. Monitoring should consider not only the number of therapy services furnished, but also whether beneficiaries are receiving the appropriate type, frequency, intensity, and duration of speech-language pathology services based on their clinical needs. As patient acuity and patterns of post-acute care continue to evolve, such monitoring will be important to ensure that payment

incentives do not inadvertently contribute to underutilization of necessary therapy services or compromise patient outcomes.

Simultaneously, ASHA believes that changes in the way Medicare pays for health care services could lead to an increase in therapy provision in future years. Given the implementation of the Transforming Episode Accountability Model (TEAM) and the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model under the inpatient prospective payment system, ASHA anticipates that home health agencies may increasingly serve higher-acuity patients transitioning from the hospital who might have otherwise received care in an inpatient rehabilitation facility or skilled nursing facility. These patients may have complex communication, cognitive, and swallowing needs that require timely access to speech-language pathology services as part of the home health plan of care.

As CMS continues to analyze the data associated with cost, payment, and service delivery, it should carefully consider all factors—such as the TEAM and CJR-X models—that might be driving changes in care patterns. Any assumption that increased utilization is associated with fraud, waste, and abuse alone would fail to consider the totality of factors that drive such changes.

## **Section II.F. Palliative Care Services as Home Health Services**

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In the proposed rule, CMS highlights that the current home health prospective payment system framework is broad enough to support palliative care without significant regulatory modifications. Specifically, home health services may be covered when they require the skills of a qualified clinician, such as an SLP, and are provided to improve, maintain, prevent, or slow the deterioration of a patient's functional status. ASHA appreciates CMS' reinforcement of coverage for maintenance therapy, particularly because the misconception that Medicare coverage requires a patient to demonstrate improvement persists despite the agency's efforts to dispel this myth following the 2013 *Jimmo v. Sebelius* ruling.

ASHA also appreciates CMS' recognition of the important role SLPs can play in palliative care. As noted in the proposal, SLPs can support safe and comfortable eating and drinking, address cognitive-communication needs, and facilitate communication and decision making for those patients with a wide range of serious and progressive conditions.<sup>1,2,3</sup> SLPs can also help establish communication access for patients whose speech, language, cognition, or other communication abilities affect their ability to express symptoms, preferences, goals, and care decisions. Through individualized strategies, augmentative and alternative communication, caregiver training, and collaboration with the interdisciplinary care team, SLPs can help patients remain active participants in their care while supporting comfort, autonomy, and quality of life.

CMS states that it plans to add examples of skilled palliative care services to the Medicare Benefit Policy Manual following publication of the CY 2027 final rule and solicits stakeholder input on its efforts to promote access to community-based palliative care. To inform that guidance and illustrate the important role of speech-language pathology services within the home health benefit, ASHA offers the following examples of how SLPs may provide skilled palliative care to address swallowing, cognition, and communication needs while supporting patient preferences, functional independence, comfort, and quality of life.

### **Swallowing**

An 88-year-old with end-stage Alzheimer's disease is receiving home health care following a hospitalization for aspiration pneumonia. A modified barium swallow study completed during the

hospital stay showed aspiration on all consistencies except for pureed food and extremely thick liquids. At home, the patient does not eat the modified diet and is losing weight quickly.

An SLP is consulted to evaluate swallowing in the home environment and to help the patient's family and care team weigh the impact of consistent aspiration against the patient's comfort, preferences, and quality of life. Together, they develop a care plan that prioritizes comfort and quality of life, and that includes caregiver training. The SLP identifies and trains the family on facilitating strategies such as presentation of small amounts of preferred food and liquids, oral care, social connection, and attentive feeding to support comfort, enjoyment, and meaningful quality of life despite significant swallowing impairment.

### **Cognition**

A 68-year-old, who lives alone and has a history of triple coronary artery bypass graft, brainstem stroke, and diabetes, is receiving home health care following hospitalization and inpatient rehabilitation for a severe traumatic brain injury. Their cognition has improved to the point that they are alert and oriented to person, place, time, and situation. However, they continue to struggle with occasional forgetfulness and have been experiencing depression following their perceived loss of independence.

An SLP works with the patient to develop cognitive supports and incorporate technology to help manage instrumental activities of daily living. The SLP also trains their son, who visits several times each week, in cueing and other strategies to help the patient accurately and safely manage their schedule, medications, and finances and remain as independent as possible at home.

### **Communication**

A 94-year-old with a history of hypertension, hyperlipidemia, and myocardial infarction is receiving home health care at their independent living facility following a stroke. The patient has Broca's aphasia and is unable to consistently communicate their wants, needs, and care preferences to their care team or to communicate with family members who live several states away.

An SLP helps establish augmentative and alternative communication strategies and trains the patient's family, caregivers, and others in their community to use communication supports, environmental modifications, multimodal communication, and other communication repair strategies. These interventions help ensure that the patient can participate meaningfully in their care planning decisions and maintain important social connections that support their quality of life.

### **Section III.D. Opportunities for Potential Alignment Between the HH QRP and the Expanded HHVBP Model**

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ASHA supports CMS' interest in meaningful home health quality measurement. However, we remain concerned that quality measures fail to capture many functional outcomes that are central to patients' health, safety, independence, and ability to participate in their own care. Expansion of functional outcome measures can achieve our mutual goals of improving the quality and outcomes of care as well as lead to longitudinal decreases in cost of care. These include outcomes related to communication, hearing, cognition, swallowing, nutrition and hydration, and caregiver training, all of which are important core components of patient-centered outpatient care and may help reduce avoidable downstream utilization and costs.

Meaningful functional outcome measurement is especially important in the home health setting, where maintaining or improving function can help patients remain safely in the community and avoid preventable complications or higher-acuity care. Caregiver training and education can also support sustained function and successful carryover of treatment strategies at home.

Therefore, ASHA urges CMS to consider a more comprehensive approach to quality measurement that recognizes communication, hearing, cognition, swallowing, nutrition and hydration, caregiver training, and other functional outcomes as core components of patient-centered care. Failing to capture holistic functional outcomes creates an incomplete picture of care quality and may leave beneficiaries vulnerable to significant health risks and lead to avoidable costs to Medicare.

### **Section III.F. HH QRP Measure Concepts Under Consideration for Future Years—Request for Information (RFI)**

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When considering the addition of the Advance Care Planning measure in the HH QRP, ASHA recommends that CMS recognize communication access as essential to valid patient participation in such planning.<sup>4</sup> Communication disorders impact patients with a wide variety of diagnoses across the lifespan, including but not limited to hearing loss, brain injury, cancer, heart disease, stroke, chronic obstructive pulmonary disease, Down syndrome, ALS, Parkinson's disease, and dementia.

Audiologists and SLPs serve as valuable members of interprofessional collaborative care teams by ensuring patients have communication access. Communication access means that people with communication disabilities can fully engage in various services, particularly in health care settings, by utilizing necessary communication supports. This concept is crucial for promoting effective communication, which is a fundamental human right. When communication barriers are present, individuals may face significant challenges in accessing and communicating wants and needs, leading to poorer health outcomes.

Health care professionals outside of audiology and speech-language pathology—who likely receive limited training in the area of communication— may not recognize or be familiar with how to accommodate hearing loss, mild cognitive impairment, aphasia from a past stroke, residual effects of cardiac events, use of augmentative and alternative communication, stuttering, articulation disorders, and other communication difficulties. Audiologists and SLPs are uniquely qualified to identify and address these barriers through supported communication strategies, augmentative and alternative communication, accessible verbal and written materials, and care partner involvement.

Without appropriate communication supports, nurses, physicians, and other health care professionals may not be able to communicate effectively with patients, potentially compromising the integrity of advance care planning discussions and the patient's ability to participate meaningfully in shared decision making and informed consent. Providing care and planning 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.<sup>5,6,7,8,9</sup>

Incorporating audiologists and SLPs effectively into advance care planning, when appropriate will help ensure that patients understand their options, communicate their preferences, and participate fully in decisions about their care.

**V.B. DMEPOS Encounter Requirements for Identical Replacement Items**

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CMS proposes a regulatory change that would clarify that while an order would continue to be required for replacement DMEPOS items, a new face-to-face encounter would not need to occur to support payment for replacement of DMEPOS items if the replacement falls under the same Healthcare Common Procedure Coding System (HCPCS) code.

SLPs often work with patients who need durable medical equipment such as speech-generating devices (SGDs). For patients with ALS, autism, or other disorders with an associated speech, language, voice, or similar communication disorder who cannot communicate needs due to a damaged or lost SGD, waiting for a face-to-face encounter to replace the item can be challenging at best. Allowing providers to order a replacement item of the same type without this in-person encounter reduces burden for the patient and caregiver and ensures more timely access to the equipment the multidisciplinary care team has determined is medically necessary for the patient.

Therefore, ASHA supports this regulatory modification and encourages CMS to adopt it as proposed.

**V.C. Provider Enrollment**

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ASHA supports program integrity policies that protect both beneficiaries and the Medicare Trust Fund. However, such policies must be clear, consistently applied, and proportionate to the conduct at issue. They should distinguish fraud or serious program integrity violations from good-faith administrative or technical errors and should not unnecessarily disrupt beneficiary access to qualified providers furnishing medically necessary Medicare services. Underutilization of appropriate audiology and speech-language pathology services can contribute to declining functional independence, medical complications, rehospitalizations, and ultimately increased costs to the Medicare program.<sup>10,11,12</sup>

ASHA is particularly concerned that CMS has stated that the provider enrollment proposals in this section would apply broadly to all Medicare provider and supplier types, except when specifically indicated otherwise. Given the significant reach of these changes, CMS should ensure that any finalized policies include clear and objective standards, appropriate due process protections, and consequences that are proportionate to the nature and severity of the identified noncompliance.

For example, CMS proposes to remove the existing factors used to determine whether a provider has demonstrated a pattern of submitting claims that fail to meet Medicare requirements. These factors currently allow CMS to consider the percentage of denied claims, the nature and circumstances of the billing noncompliance, prior adverse actions, and other relevant information. CMS explains that existing factors may constrain its ability to address certain patterns of improper billing.

ASHA recognizes the need for CMS to respond effectively to conduct that threatens program integrity. However, greater enforcement flexibility should not come at the expense of appropriate checks and balances. The existing factors help CMS determine whether adverse enrollment actions are warranted based on the nature, frequency, significance, and circumstances of the conduct rather than on isolated errors or technical noncompliance. Eliminating these considerations entirely would give CMS substantially broader discretion without comparable safeguards to ensure that enforcement actions are proportionate and consistently applied.

Therefore, ASHA recommends that CMS retain objective criteria—or establish revised criteria that provide greater flexibility while preserving meaningful safeguards—to distinguish serious or repeated misconduct from inadvertent or good-faith errors.

Similarly, ASHA is concerned about CMS' proposal permitting denial of enrollment when an applicant shares office or suite space with a provider whose Medicare enrollment has been denied or revoked. Although CMS indicates that such a denial would not be automatic, physical proximity alone should not be sufficient to call a provider's eligibility into question. Shared office arrangements are common and may exist for legitimate reasons. CMS should require evidence of a meaningful ownership, financial, managerial, operational, or other type of relationship to the conduct that resulted in the other provider's denial or revocation before taking adverse enrollment action.

ASHA is also concerned about the proposal to bar reapplication for up to 10 years following any enrollment denial while eliminating existing factors used to determine whether a bar is warranted and its appropriate duration. CMS should reserve a consequence of this magnitude for serious program integrity violations and support the bar with objective criteria that consider the nature and severity of conduct. CMS should not impose lengthy reapplication bars for technical errors, incomplete enrollment information, or other circumstances that do not demonstrate fraud, intentional misconduct, or a meaningful risk to beneficiaries or the Medicare program.

Taken together, these proposals would give CMS additional tools to address serious program integrity concerns, but the effectiveness of those tools will depend on their ability to distinguish intentional or repeated misconduct from good-faith administrative errors and legitimate practice arrangements. ASHA urges CMS to pair any expanded enforcement authority with clear standards and appropriate safeguards that promote consistent, proportionate decision making.

At a minimum, CMS should retain objective criteria for evaluating noncompliance, provide reasonable opportunities to correct good-faith administrative deficiencies, establish a meaningful connection before attributing another provider's conduct to an applicant, and reserve the most significant consequences for conduct that poses a substantial risk to beneficiaries or the Medicare program. These protections would support CMS' program integrity objectives while minimizing unintended disruptions to legitimate Medicare participation and beneficiary access to medically necessary care.

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

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