ASHA
American
Speech-Language-Hearing
Association

September 14, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), we write in response to the calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) 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. Audiologists and SLPs provide services paid under the MPFS in a variety of practice settings, including private practices and skilled nursing facilities.

The proposed rule includes several policies critical to the continued viability of audiology and speech-language pathology practices, including the transition to new procedure codes for both professions; the move from the Merit-based Incentive Payment System (MIPS) to MIPS Value Pathways (MVPs), and requests for information concerning the future of Medicare payment and care delivery.

Across these proposals, ASHA urges CMS to protect beneficiary access to medically necessary services by ensuring accurate and sustainable payment, recognizing functional outcomes and communication needs, minimizing unnecessary administrative burdens and barriers to care, and appropriately incorporating the expertise of audiologists and SLPs to improve outcomes and advance high-quality and patient-centered care.

ASHA's comments focus on the following areas:

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Section II.B. Determination of Practice Expense Relative Value Units

ASHA appreciates CMS' continued efforts to improve the accuracy and transparency of the practice expense (PE) methodology. However, ASHA is concerned that the proposed changes could significantly redistribute PE relative value units (RVUs) for many services that appropriately include little or no clinical labor in their direct PE inputs, including audiology and speech-language pathology services.

CMS proposes three interrelated changes to the PE methodology: revising Step 8 to include both work RVUs and clinical labor PE RVUs in the indirect allocator for nearly all services; phasing out the Indirect Practice Cost Index (IPCI) over two years; and establishing a 5% annual stabilization adjustment for PE RVUs. Because CMS proposes to implement these changes simultaneously, stakeholders cannot readily determine their individual and combined effects. CMS has not demonstrated that the resulting distribution would more accurately reflect the indirect costs of furnishing services across different clinical service delivery models.

Proposed Step 8 in Practice Expense Methodology Would Disadvantage Personally Furnished Services

Under the current methodology, CMS generally calculates the indirect PE allocator for nonglobal services using either work RVUs or clinical labor PE RVUs, depending on which is greater. For services that may be reported using professional, technical, and global components—referred to by CMS as "triplet services"—the current methodology includes both work RVUs and clinical labor PE RVUs. CMS proposes extending this approach to nearly all MPFS services, except codes with 010- and 090-day global periods.

Under CMS' proposed methodology, however, services that include both physician work and clinical labor RVUs would receive a proportionally larger allocation of indirect PE. Services that do not include clinical labor would receive no comparable recognition, even though they incur substantial indirect cost associated with maintaining a practice. Because indirect PE is allocated from a fixed pool under budget neutrality, increasing the allocation to services with clinical labor could reduce the indirect PE allocated to services furnished without it. This approach risks disadvantaging services based on their staffing model rather than their actual indirect practice costs.

For services without clinical labor PE RVUs, the proposed Step 8 formula may not directly change the inputs to their individual allocators. However, adding clinical labor PE RVUs to the allocators for other services increases those services' relative claims on the fixed pool of indirect PE, the subsequent scaling adjustment would reduce the relative share available to services whose allocators did not increase.

This is particularly concerning for audiology and speech-language pathology services. Most of these services are personally furnished by the billing audiologist or SLP and therefore include little or no separate clinical labor in their direct PE inputs. Although the qualified health care professional's (QHP's) clinical time is generally reflected in the work RVU, the practice continues to incur the administrative, technological, compliance, occupancy, and other indirect practice expenses necessary to support audiology and speech-language pathology services. The absence of separate clinical labor does not establish that indirect expenses are lower. CMS also has not demonstrated that services supported by greater amounts of clinical labor necessarily incur proportionally greater indirect expenses. Therefore, clinical labor PE RVUs are an incomplete proxy for the indirect costs of furnishing a service.

Practices in which the QHP personally furnishes the service may also have fewer opportunities to distribute fixed overhead across services furnished concurrently by clinical staff. ASHA urges CMS to evaluate whether adding clinical labor PE RVUs to the indirect allocator systematically favors staff-supported delivery models over services that must be personally furnished by the billing clinician. Medicare payment policy should not disadvantage services because they are personally furnished by qualified clinicians whose expertise is required to provide care safely and effectively. Systematically reducing payment for these services could further strain practice sustainability and limit Medicare beneficiaries' access to medically necessary audiology and speech-language pathology care.

ASHA's analysis of CMS' proposed inputs confirms that the Step 8 change would produce markedly different increases in service-level indirect allocators depending on the relative amounts of work and clinical labor PE RVUs assigned to each service. Services with similar work and clinical labor PE RVUs would receive the largest initial increases—potentially nearly doubling this portion of the allocator—while services with little or no clinical labor would receive a substantially smaller increase or no increase at all. Although subsequent scaling and other elements of the PE methodology affect the final PE RVUs, the proposed formula gives certain services greater initial claim on the available indirect PR pool based on their staffing structure. CMS has not demonstrated that these differences correspond to actual differences in indirect practice costs.

ASHA compared the CY 2026 final and CY 2027 proposed nonfacility PE RVUs for existing audiology and speech-language pathology codes. This analysis indicated that a significant number of services would experience reductions in their nonfacility PE RVUs. New codes without prior-year RVUs were excluded from this comparison. The table below illustrates the potential combined impact of the proposed CY 2027 PE RVUs and the nonqualifying alternative payment model (APM) conversion factor on selected audiology and speech-language pathology services. **This table is illustrative and not an exhaustive list.**

CPT Code	Short Descriptor	CY 2026 Nonfacility PE RVUs	CY 2027 Proposed Nonfacility PE RVUs	PE RVU Change (%)	Estimated National Nonfacility Payment Change*
92517	Vemp test i&r cervical	1.40	1.33	-5%	-$3.53
92625	Tinnitus assessment	0.80	0.75	-5%	-$3.07
92526	Oral function therapy	1.17	1.11	-4%	-$3.38

CPT Code	Short Descriptor	CY 2026 Nonfacility PE RVUs	CY 2027 Proposed Nonfacility PE RVUs	PE RVU Change (%)	Estimated National Nonfacility Payment Change*
92611	Motion fluoroscopy/swallow	1.38	1.31	-4%	-$3.83

*Estimated payment changes compare the geographically unadjusted CY 2026 and proposed CY 2027 national nonfacility payment amounts using the applicable nonqualifying APM conversion factors. The estimates reflect changes in total RVUs and the conversion factor and should not be interpreted as attributable solely to the proposed PE methodology.

CMS explains that the Step 8 proposal is intended to correct an advantage created by the special formula used to maintain relativity among the professional, technical, and global components of triplet services. ASHA supports correcting any demonstrated distortion in the current methodology. However, CMS has not demonstrated that applying the triplet-service formula across nearly the entire MPFS is the most accurate or least disruptive way to correct the identified issue.

Rather than broadly applying the additive formula, CMS should evaluate a targeted approach that corrects the identified triplet-service advantage while preserving the required relativity among the professional, technical, and global components. At a minimum, CMS should separately model the effects of the Step 8 change on services with and without clinical labor PE RVUs and demonstrate that the resulting distribution reflects measurable differences in indirect practice costs.

Therefore, ASHA urges CMS not to finalize the proposed Step 8 change for CY 2027. CMS should retain the current indirect PE allocator while it analyzes and publicly reports the proposal's redistributive effects and develops a more targeted solution to the triplet-service anomaly identified in this proposed rule.

CMS Should Retain the IPCI Until It Develops a Validated Replacement

ASHA is also concerned with CMS' proposal to phase out the Indirect Practice Cost Index (IPCI). ASHA recognizes that the IPCI relies largely on aging Physician Practice Information Survey (PPIS) data and supports modernizing the information used to account for specialty-level indirect expenses. However, the IPCI has historically provided a specialty-level adjustment that recognizes differences in indirect practice costs that may not be reflected in code-level PE inputs.

CMS proposes to reduce the IPCI's influence by half in CY 2027 and eliminate the IPCI-based steps of the PE methodology the following year. However, CMS has not identified a validated replacement for the specialty-level information the IPCI supplies. Reducing and ultimately eliminating the IPCI while also revising the Step 8 allocator could compound the redistribution of indirect PE away from services with little or no clinical labor, including audiology and speech-language pathology services. These changes could result in significant payment reductions for these impacted specialties.

The proposed 5% stabilization adjustment, discussed in more detail below, may limit the pace of annual PE changes for some services, but it does not establish that the underlying allocation is

accurate. In addition, the proposed stabilization adjustment would not initially apply to new, revised, revalued, or newly nationally priced codes. Stabilization therefore cannot substitute for a sound methodology that appropriately captures differences in indirect practice costs.

ASHA urges CMS to retain the IPCI until the agency has developed and validated a replacement methodology that captures specialty-level differences in indirect practice costs.

Before implementing these changes, CMS should publish separate analyses showing the effects of (1) revising the Step 8 indirect PE allocator, (2) reducing and ultimately eliminating the IPCI, (3) applying the proposed stabilization adjustment, and (4) implementing these policies concurrently. The analysis should report the combined effects on individual services and specialties.

These analyses are necessary for stakeholders to determine which components of the revised methodology are driving particular changes and to provide CMS meaningful feedback. They are especially important when more than one major methodological change would be implemented concurrently.

Extend the 5% PE Stabilization Policy to Replacement Code Families

If CMS finalizes the proposed PE methodology despite these concerns, ASHA requests that the agency extend the proposed 5% PE stabilization policy to new and revised replacement code families. CMS specifically recognizes the potential value of extending stabilization to these codes and solicits comments on the appropriate methodology for doing so.

New or revised successor codes often lack directly comparable prior-year PE RVUs. Applying the full prior-year PE RVU of a deleted code separately to each successor code would not provide an appropriate comparison when one service is being replaced by multiple codes with different resource requirements. Instead, CMS should apply stabilization at the code-family level by comparing the aggregate, utilization-weighted PE RVUs of the new or revised code(s) with the aggregate PE RVUs of the deleted code(s).

CMS could use its published CY 2026-to-CY 2027 analytic crosswalk and projected utilization for the new and revised codes to establish the comparison and then distribute any necessary stabilization adjustment proportionally among the successor codes. Specifically, CMS should apply this approach to:

- the new speech-language pathology treatment code family 92X0X–92X9X, which replaces CPT code 92507;
- the new rotational vestibular assessment codes 92XX5 and 92XX6, which replace CPT code 92546; and
- the new video head impulse testing codes 92X10 and 92X11, for which CMS has crosswalked a portion of CPT code 92700 utilization.

Because CPT code 92700 is an unlisted service that may represent procedures other than video head impulse testing, CMS should use only the portion of historical 92700 utilization reasonably attributable to those services when constructing the family-level comparison.

This protection is particularly important because these services would be affected **by two significant changes simultaneously: implementation of new or replacement CPT code families and substantial revisions to the PE methodology.** Replacing a CPT code should not

prevent the underlying service from receiving the protection CMS intends to provide through its stabilization policy merely because the new code lacks a directly comparable prior-year PE value.

A family-level, utilization-weighted approach would protect against abrupt PE changes without treating each new code as equivalent to the entire predecessor service. It would also build on the analytic crosswalk CMS has already developed for rate setting purposes.

Stabilization is a secondary safeguard and does not resolve ASHA's fundamental concerns with the proposed methodology. Accordingly, **ASHA urges CMS to:**

- retain the current Step 8 methodology while developing and evaluating a more targeted response to the triplet-service issue;
- maintain the IPCI until a validated replacement is available;
- publish disaggregated code- and specialty-level impact analyses of the combined effects of the proposed PE changes; and
- extend appropriate family-level stabilization protections to new and revised replacement codes.

Section II.C. Payment for Medicare Telehealth Services

ASHA is concerned that CMS did not propose adding the 10 new CPT codes for speech-language pathology treatment services that will replace CPT code 92507 effective January 1, 2027, to the Medicare Telehealth Services List. Because the new codes replace a service already included on the list and describe the same clinical services with greater specificity, the omission appears inadvertent and should be corrected in the final rule.

In the CY 2021 Medicare Physician Fee Schedule final rule, CMS established a process for making technical refinements to the Medicare Telehealth Services List when coding changes occur. CMS finalized its policy under which it would add that when new codes replace codes describing the same clinical services already on the list, the agency would include the new codes and update the list accordingly.[1]

The policy is consistent with 42 CFR § 410.78(f), which provides that changes to the Medicare Telehealth Services List are made through the annual physician fee schedule rulemaking process and that CMS maintains the current Healthcare Common Procedure Coding System (HCPCS) codes describing those services on its website. ASHA's review of the final MPFS rules issued from CY 2021 through CY 2026 identified no repeal or modification of the successor-code policy.

CMS also applied this policy when previous coding changes occurred. Following revisions to the inpatient and outpatient hospital observation care code set effective January 1, 2023, CMS replaced seven predecessor codes from the Medicare Telehealth Services List with their nine successor codes.[2]

Neither section 1834(m) of the Social Security Act nor 42 CFR § 410.78(f) conditions such a technical update contingent upon CMS receiving an external request. Therefore, CMS has the authority to correct this omission through the current rulemaking. Failure to add the successor codes would interrupt Medicare telehealth coverage for established speech-language pathology services solely because the services are transitioning to a more specific coding structure. This

could limit access for beneficiaries who rely on telehealth because of geographic, mobility, transportation, or other barriers to in-person care.

Therefore, ASHA respectfully requests that CMS recognize CPT codes **92X0X, 92X1X, 92X2X, 92X3X, 92X4X, 92X5X, 92X6X, 92X7X, 92X8X, and 92X9X** as successor codes to CPT code 92507 and add all 10 codes to the Medicare Telehealth Services List effective January 1, 2027.

If CMS finalizes HCPCS code GSLPP despite the concerns discussed later in this letter, ASHA also requests that CMS add GSLPP to the Medicare Telehealth Services List as it has proposed. Like the 10 successor CPT codes, GSLPP would describe treatment services currently reported under CPT code 92507. Finalizing its addition would preserve access to those services through.

Section II.D. Valuation of Specific Codes, Including Potentially Misvalued Codes

ASHA appreciates CMS' consideration of the resources required to furnish the services reviewed in this section. We offer the following recommendations to support accurate valuation, sustainable access to care, and clear and consistent implementation of codes discussed below.

(38) Rotational Vestibular Assessment (CPT codes 92XX5 and 92XX6)

Beginning January 1, 2027, CPT code 92546 will be deleted and replaced by two new codes describing rotational vestibular assessment using sinusoidal harmonic acceleration (SHA) and velocity step testing (VST).

ASHA appreciates CMS' proposal to add CPT codes 92XX5 and 92XX6 to the audiology services list and accept the AMA/Specialty Society Relative Value Scale Update Committee (RUC)-recommended direct PE inputs for both codes. ASHA also supports CMS' proposal to accept the RUC-recommended work RVU of 0.92 for CPT code 92XX5. However, ASHA disagrees with CMS' proposal to reduce the work RVU for CPT code 92XX6 from the RUC-recommended value of 0.48 to 0.35. ASHA urges CMS to accept the RUC-recommended work RVU because it more accurately reflects the intensity and complexity of the physician's or other qualified health care professional's work required to furnish the add-on service.

CMS' rationale for reducing the value of CPT code 92XX6 focuses primarily on the difference in work time between the base code and the add-on code. CMS notes that CPT code 92XX6 includes 12 minutes of work time, compared with 45 minutes for CPT code 92XX5, and concludes that the work intensity of the add-on service should not be approximately twice that of the base code. However, work RVUs are not determined by time alone. The RUC also evaluates **technical complexity, cognitive effort, clinical judgment, mental effort, and psychological stress**.

The RUC's recommendation reflects survey data and review by practicing subject matter experts who routinely furnish these services. Although SHA testing is included in both codes, CPT code 92XX6 describes additional VST that is not included in the base service. This additional testing requires interpretation of complex vestibular physiology, integration of multiple test findings, clinical decision making, patient monitoring, and additional mental effort. The fact that CPT code 92XX6 is reported with the base code does not diminish the distinct work required to perform and interpret the additional VST. These intensity factors were fully considered by the RUC when recommending a work RVU of 0.48.

CMS acknowledges that CPT code 92XX6 has greater intensity than the base service but does not provide a sufficiently compelling clinical or methodological basis for concluding that the RUC's recommended intensity is excessive. Reducing the work RVU to the 25th percentile survey value would undervalue the complexity, clinical judgment, and mental effort associated with rotational vestibular assessment with velocity step testing and would not accurately reflect the resources required to furnish this service.

Accurate valuation is also important for maintaining access to comprehensive vestibular assessment. Vestibular disorders can affect balance, coordination, and spatial orientation, and may increase the risk of falls and other preventable injuries. Timely assessment helps clinicians identify the source of a patient's symptoms and determine appropriate referrals, interventions, and care planning. CMS data show that nearly one-quarter of Medicare beneficiaries living in the community experienced at least one fall in 2024, and approximately 12% experienced more than one fall. Seventeen percent of beneficiaries experienced a fall that resulted in injury, including bruises, fractures, concussions, and joint dislocations, among other medical issues.[3]

Undervaluing specialized vestibular services could make it more difficult for practices—particularly those in smaller or underserved communities—to maintain access to this care. Falls and related injuries are more than mere inconveniences for patients and their caregivers. They can result in pain, loss of independence, hospitalization, rehabilitation, and other health care services that increase both Medicare spending and beneficiaries' out-of-pocket costs. Accordingly, ASHA strongly urges CMS to accept the RUC-recommended work RVU of **0.48** for CPT code **92XX6**.

Efficiency Adjustment

CMS' finalized efficiency adjustment policy exempts time-based services and new codes from this payment reduction. Because these CPT codes are new, they should not be subject to the efficiency adjustment. Therefore, ASHA requests that CMS confirm in the final rule and associated coding files that CPT codes 92XX5 and 92XX6 are exempt from the efficiency adjustment.

ASHA continues to oppose the efficiency adjustment, consistent with concerns raised in our previous comments to CMS. ASHA believes this adjustment represents an arbitrary and inappropriate reduction to CPT code values that is not supported by sufficient data or evidence demonstrating that the affected services have become more efficient over time. Without a clear, evidence-based rationale, applying a broad efficiency adjustment risks undervaluing services and undermining the accuracy of Medicare payment.

(39) Video Head Impulse Vestibular Function (CPT Codes 92X10 and 92X11)

Effective January 1, 2027, two new CPT codes will be added to describe video head impulse testing of vestibular function. ASHA appreciates CMS' proposal to add CPT codes 92X10 and 92X11 to the audiology services list, accept the RUC-recommended work RVUs of 0.53 and 0.84, respectively, and accept the RUC-recommended direct PE inputs without refinement. ASHA urges CMS to finalize this proposal.

Efficiency Adjustment

CMS' finalized efficiency adjustment policy exempts time-based services and new codes from this payment reduction. Because these CPT codes are new, they should not be subject to the efficiency adjustment. Therefore, ASHA requests that CMS confirm in the final rule and

associated coding files that CPT codes 92X10 and 92X11 are exempt from the efficiency adjustment.

ASHA continues to oppose the efficiency adjustment, consistent with concerns raised in our previous comments to CMS. ASHA believes this adjustment represents an arbitrary and inappropriate reduction to CPT code values that is not supported by sufficient data or evidence demonstrating that the affected services have become more efficient over time. Without a clear, evidence-based rationale, applying a broad efficiency adjustment risks undervaluing services and undermining the accuracy of Medicare payment.

(40) Speech-Language Pathology Services (CPT codes 92X0X, 92X1X, 92X2X, 92X3X, 92X4X, 92X5X, 92X6X, 92X7X, 92X8X, 92X9X, and 92508)

ASHA supports CMS' proposal to adopt the 10 new CPT codes established to replace CPT code 92507 effective January 1, 2027, and to accept the RUC-recommended work RVUs and direct PE inputs for the new codes and CPT code 92508. The new code family is the product of an extensive and deliberate code development and valuation process intended to reflect current clinical practice more accurately. Adoption of the new codes and recommended values will support more precise reporting and payment, produce more useful utilization data, and strengthen Medicare program integrity.

After the RUC's Relativity Assessment Workgroup (RAW) identified CPT code 92507 for review, ASHA, as the national specialty society representing SLPs, participated extensively in the CPT code development and valuation process. Working with subject matter experts and practicing clinicians, ASHA developed 10 CPT codes to replace 92507. The new codes more accurately describe contemporary practice and improve transparency regarding the nature and duration of the interventions furnished. Therefore, ASHA urges CMS to finalize the new code set and the RUC-recommended work RVUs and direct PE inputs as proposed.

Why a New Code Family Was Necessary

The new code family addresses several limitations of CPT code 92507, including concerns related to utilization, its broad and outdated description, and its inability to distinguish among contemporary speech-language pathology interventions.

Utilization Growth Prompted Review

In 2024, the AMA's RAW identified CPT code 92507 through the high-volume growth screen after utilization increased by more than 100% between 2017 and 2022. Identification through the screen prompted further review but did not, by itself, determine the reason for the increase. The review demonstrated the limitations of using one broadly defined, untimed code to report a wide range of speech-language pathology interventions. The new code family provides greater specificity regarding the nature and duration of services furnished, supporting more accurate reporting and meaningful analysis of utilization patterns.

CPT Code 92507 No Longer Reflected Contemporary Clinical Practice

CPT code 92507 was developed over 30 years ago and was last reviewed for valuation in 2010. Since then, advances in technology, changes in the populations served by SLPs, and the continued evolution of evidence-based intervention approaches have substantially altered clinical practice. The code's broad descriptor no longer provided sufficient specificity to distinguish among the range of interventions reported under it.

The need for greater specificity was also evident in the disconnect between evaluation and treatment coding. Since 2013, SLPs have reported disorder-specific evaluation codes, while most corresponding treatment services continued to be reported under 92507. The new code family better aligns the evaluation and treatment coding frameworks and allows Medicare to distinguish both the type and duration of the services furnished.

A Timed Structure Better Reflects Treatment Duration

As an untimed code, CPT code 92507 provided no information about the duration of the services furnished. The new code family addresses this limitation through 30-minute base codes and 15-minute add-on codes. This structure reflects typical clinical practice while allowing flexibility to provide shorter or longer treatment sessions when warranted by the patient's clinical needs. It also supports more accurate reporting and better aligns payment with the time and resources required to furnish care.

Implementation Considerations

In addition to finalizing the new code family and recommended values, CMS must address several implementation policies that will affect how these services are reported and paid. ASHA offers the following recommendations to support an accurate and orderly transition and avoid unintended barriers to care.

Efficiency Adjustment

CMS' finalized efficiency adjustment policy exempts time-based services and new codes from this payment reduction. Because the 10 replacement CPT codes are both new and time-based services, they should not be subject to the efficiency adjustment. Moreover, the principal resources associated with these services are the clinician's time, clinical judgment, and effort during direct treatment. These resources do not diminish as clinicians gain experience. Therefore, ASHA requests that CMS confirm in the final rule and associated coding files that CPT codes 92X0X through 92X9X are exempt from the efficiency adjustment.

ASHA continues to oppose the efficiency adjustment, consistent with concerns raised in our previous comments to CMS. ASHA believes this adjustment represents an arbitrary and inappropriate reduction to CPT code values that is not supported by sufficient data or evidence demonstrating that the affected services have become more efficient over time. Without a clear, evidence-based rationale, applying a broad efficiency adjustment risks undervaluing services and undermining the accuracy of Medicare payment.

Multiple Procedure Payment Reduction (MPPR) Policy

CMS proposes to designate all five new base CPT codes as "always therapy services." The five add-on CPT codes would be classified as "sometimes therapy services." Because the base codes are "always therapy services," CMS also proposes to apply the multiple procedure payment reduction (MPPR) to the five 30-minute base codes. The five 15-minute add-on codes—92X1X, 92X3X, 92X5X, 92X7X, and 92X9X—would be excluded from this payment reduction.

ASHA continues to oppose application of the MPPR to therapy services because the policy reduces payment for practice expenses that are not necessarily duplicated when multiple services are furnished during the same encounter. Nevertheless, if CMS applies the MPPR to the five base codes, ASHA urges CMS to finalize its proposal to exclude the five add-on codes from the reduction.

National Correct Coding Initiative Edits

The transition from the broad descriptor associated with CPT code 92507 to more specific, disorder-based codes requires a corresponding review of Medicare's National Correct Coding Initiative (NCCI) procedure-to-procedure edits. Existing edits associated with CPT code 92507 should not automatically be transferred to every successor code. Instead, each potential edit should be evaluated based on whether the services described by the new code pair involve actual duplication.

In particular, CMS should not establish edits that categorically prohibit reporting CPT codes 97129 and 97130 on the same date as the new speech-language pathology treatment codes. An SLP may furnish medically necessary cognitive treatment and a separate treatment service addressing speech, language, voice, or fluency during the same encounter. When the services address distinct clinical needs, involve separate treatment activities, and are appropriately documented, they should be eligible for separate payment.

Our recommendations are as follows:

Code	Recommended NCCI Edit Pairs	Modifier Permitted (Y/N)	Code Pairs for Which No Edit Is Recommended
92X0X: Treatment of Fluency Disorder; Initial 30-minute Base Code	97153, 97155	92508, 97150 (Y)	31579, 92511, 92520, 92521, 92522, 92523, 92524, 92526, 92597, 92605, 92618, 92606, 92607, 92608, 92609, 92610, 92611, 92612, 92613, 92614, 92616, 92617, 92626, 92627, 92630, 92633, 96105, 96112, 96113, 96125, 97129, 97130, 97550, 97551, 97552, 92700
92X1X: Treatment of Fluency Disorder; Each Additional 15-Minute Add-on Code	97153, 97155	92508, 97150 (Y)	
92X2X: Treatment of Speech Sound Production Disorder; Initial 30-minute Base Code	97153, 97155, 92X4X, 92X5X, 92X6X, 92X7X	92508, 97150 (Y)	
92X3X: Treatment of Speech Sound Production Disorder; Each Additional 15-Minute Add-on Code	97153, 97155, 92X4X, 92X5X, 92X6X, 92X7X	92508, 97150 (Y)	
92X4X: Treatment of Language Comprehension and Expression Disorder; Initial 30-minute Base Code	97153, 97155, 92X1X, 92X2X, 92X6X, 92X7X	92508, 97150 (Y)	
92X5X: Treatment of Language Comprehension and Expression Disorder; Each Additional 15-Minute Add-on Code	97153, 97155, 92X1X, 92X2X, 92X6X, 92X7X	92508, 97150 (Y)	
92X6X: Treatment of Speech Sound Production Disorder and Language Comprehension and Expression Disorder; Initial 30-minute Base Code	97153, 97155, 92X2X, 92X3X, 92X4X, 92X5X	92508, 97150 (Y)	

Code	Recommended NCCI Edit Pairs	Modifier Permitted (Y/N)	Code Pairs for Which No Edit Is Recommended
92X7X: Treatment of Speech Sound Production Disorder and Language Comprehension and Expression Disorder; Each Additional 15-Minute Add-on Code	97153, 97155, 92X2X, 92X3X, 92X4X, 92X5X	92508, 97150 (Y)	
92X8X: Treatment of Voice, Upper Airway and/or Resonance Disorders; Initial 30-minute Base Code	97153, 97155	92508, 97150 (Y)	
92X9X: Treatment of Voice, Upper Airway and/or Resonance Disorders; Each Additional 15-Minute Add-on Code	97153, 97155	92508, 97150 (Y)	
92508: Group Treatment	97129, 97130, 97533, 97154, 97155, 97156, 97157, 97158,	N	
92508: Group Treatment	97150, 97153, 92607, 92609	Y	92X0X-92X9X 31579, 92511, 92520, 92521, 92522, 92523, 92524, 92526, 92597, 92605, 92618, 92606, 92607, 92608, 92609, 92610, 92611, 92612, 92613, 92614, 92616, 92617, 92626, 92627, 92630, 92633, 96112, 96113, 96125, 97129, 97130, 97550, 97551, 97552, 92700

Billing of Time-Based Codes

CPT guidance generally provides that a unit of time is attained when more than half of the stated time has elapsed, unless the code descriptor or accompanying instructions specify otherwise.

> AMA CPT Professional Edition 2026*, "A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and 60 minutes). A second hour is attained when a total of 91 minutes has elapsed; unless code-specific or code-range-specific instructions, guidelines, parenthetical notes, or code descriptors provide otherwise).*

Consistent with this longstanding convention, ASHA urges CMS to apply the same standard to these time-based codes.

Under the CPT midpoint convention, a 30-minute code would be reportable at 16 minutes. Similarly, a 15-minute add-on code at 8 minutes and would be reportable after the initial 30-minute interval and at least eight additional minutes of treatment, or at 38 total minutes. CMS should clarify how time should be counted when an SLP furnished services addressing more than one disorder area or reports another timed therapy service during the same encounter. Applying the midpoint rule within this time-based framework is essential because it gives clinicians the flexibility to tailor treatment duration to the patient's clinical needs. Some patients may be unable to tolerate a full 30-minute session due to fatigue, medical complexity, attention limitations, or other clinical factors. In other cases, a patient may need treatment across multiple disorder areas during the same encounter, requiring clinicians to allocate time in a manner that best supports the patient's goals. Conversely, when a patient would benefit from a longer session, the availability of add-on codes allows clinicians to extend treatment appropriately.

Therefore, ASHA encourages CMS to continue applying the midpoint rule to these time-based codes. This approach is consistent with CPT guidance, supports accurate reporting, and preserves the clinical flexibility necessary to furnish patient-centered care.

Addition to the Telehealth Services List

ASHA's request that CMS add the 10 successor CPT codes to the Medicare Telehealth Services List is addressed in Section II.C of these comments.

Proposed HCPCS Code GSLPP for Pediatric Speech-Language Pathology Treatment

ASHA opposes CMS' proposal to create Medicare-specific HCPCS code GSLPP for individual speech-language pathology treatment furnished to pediatric patients and urges CMS to withdraw the proposal. GSLPP would preserve the broad structure and valuation of CPT code 92507 after that code is deleted and replaced with a more specific, time-based code family. Rather than addressing a service not represented in the new CPT codes, GSLPP would duplicate services already described by those codes, divide reporting based on the patient's age and payer, and recreate the limitations associated with the deleted code 92507.

CMS Has Not Demonstrated a Need for a Separate Pediatric Code

CMS states that interested parties expressed concern that the 10 new CPT codes do not accurately capture the time and intensity of services furnished to pediatric patients. However, the proposed rule provides no clinical data, utilization analysis, survey results, or other evidence demonstrating that pediatric speech-language pathology treatment differs fundamentally from treatment provided to other populations in a way that warrants a separate Medicare-specific coding structure.

Furthermore, pediatric services were directly considered in developing and valuing the new CPT code family. Three of the five clinical vignettes used during the CPT and RUC processes involved pediatric patients and reflected the treatment approaches, supplies, equipment, time, and clinical judgment required to serve this population. The resulting structure includes 30-minute base codes and 15-minute add-on codes, allowing clinicians the flexibility to provide shorter or longer treatment times when warranted by an individual patient's needs.

GSLPP Would Recreate the Limitations of CPT Code 92507

ASHA is concerned that CMS' proposal to preserve the deleted legacy CPT code 92507 through GSLPP would perpetuate the same limitations that prompted 92507 to be identified for review and ultimately replaced.

Utilization Concerns

As noted above, CPT code 92507 was identified for review because of significant growth in Medicare utilization. This growth was influenced by the broad nature of the code, which encompassed multiple distinct speech-language pathology services under a single umbrella code. The combination of limited clinical specificity and an untimed coding structure made it difficult to distinguish among the services furnished and accurately characterize patterns of care.

Preserving the legacy structure of CPT code 92507 through GSLPP would not address these underlying concerns. Rather, it risks recreating the same lack of specificity and utilization challenges that contributed to the review of 92507 and ultimately informed the development of new, more clinically specific codes. Therefore, ASHA urges CMS to avoid relying on the outdated 92507 framework and instead adopt a coding approach that appropriately reflects current SLP clinical practice, distinguishes among the specialized services furnished, and supports accurate reporting and valuation of those services.

The Proposed Descriptor and Valuation Are Internally Inconsistent

CMS proposes a work RVU of 1.30 for GSLPP based on 60 minutes of work associated with CPT code 92507. However, the proposed GSLPP descriptor does not include a time requirement and only proposes the code to be reported once per patient per day. Without an explicit time threshold, clinicians and Medicare contractors could interpret the reporting requirements differently, and the code could be reported for services substantially shorter than the 60 minutes reflected in its valuation.

This approach also conflicts with the evidence considered through the CPT and RUC processes indicating that 30 minutes represents a typical speech-language pathology treatment session. The new CPT structure addresses variation in treatment duration through 30-minute base codes and 15-minute add-on codes. CMS has not explained why an untimed code valued at 60 minutes more accurately represents pediatric care than this flexible time-based structure.

CMS also proposes to assign GSLPP the direct PE inputs associated with CPT code 92507. Because 92507 was developed more than 30 years ago and last valued in 2010, carrying its outdated inputs forward would not necessarily reflect the technology, equipment, supplies, and clinical processes used in current pediatric practice. CMS should not rely on the valuation of a deleted code without demonstrating that its work and PE inputs remain accurate.

The proposed rule also contains conflicting descriptions of the eligible population. The primary valuation discussion describes GSLPP as applying to pediatric patients "up to age 21," while the

telehealth discussion and valuation table refer to patients “up to age 18 or 21.” This inconsistency further demonstrates that the proposal is not sufficiently developed for implementation.[4]

GSLPP Would Create Unnecessary Administrative Burden

Implementing the new CPT code family will require significant updates to electronic health records, billing systems, documentation practices, coverage policies, claims edits, and clinician and payer education. Adding a Medicare-specific code that duplicates services described by the new CPT codes would require additional age- and payer-specific billing rules and complicate those implementation efforts.

It also could fragment utilization data by causing comparable services to be reported under different coding structures based solely on a beneficiary’s age. This would make it more difficult for CMS and other stakeholders to compare patterns of care, evaluate outcomes, and identify the factors driving utilization.

Recommendation

For these reasons, ASHA strongly urges CMS to finalize CPT codes 92X0X through 92X9X and their proposed values without modification and withdraw proposed HCPCS code GSLPP.

If CMS nevertheless finalizes GSLPP, ASHA requests that the agency, at a minimum:

- establish a clear age range;
- clearly define a minimum time requirement in the code descriptor to promote consistent reporting and help mitigate the potential for future utilization growth concerns;
- assess current clinical practice patterns and develop work and direct PE inputs using current pediatric practice data rather than automatically adopting the values associated with CPT code 92507;
- maintain GSLPP on the Medicare Telehealth Services List; and
- provide clear billing, documentation, MPPR, and NCCI guidance before implementation.

(48) Remote Monitoring (CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470)

ASHA supports targeted safeguards to ensure that remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services are medically necessary, appropriately furnished, accurately reported, and properly valued. However, RPM and RTM involve different clinical services, practitioners, technologies, and treatment relationships. CMS should evaluate the need for additional safeguards separately for each code family and avoid applying findings concerning RPM to RTM without evidence that the same program -integrity concerns exist.

Established-Patient and Initiating-Visit Requirements

ASHA supports CMS’s proposal to require RTM services to be furnished only to established patients. An established practitioner-patient relationship helps ensure that the practitioner understands the patient’s clinical condition and treatment plan before initiating monitoring.

ASHA also supports requiring the billing practitioner to determine the need for RTM during a separately reportable face-to-face visit, which CMS proposes could occur either in person or through telehealth. For SLPs, an appropriate Medicare-covered speech-language, cognitive, or swallowing evaluation should qualify as the initiating visit when the SLP evaluates the

beneficiary, determines that RTM is clinically appropriate, discusses RTM with the beneficiary, and satisfies the other applicable requirements. ASHA requests that CMS confirm this interpretation in the final rule or related billing guidance.

Supervision and Employment Requirements

ASHA supports CMS' goal of ensuring that the billing practitioner remains meaningfully involved in remote monitoring services. However, employment status alone does not necessarily establish the degree of clinical integration, supervision, or practitioner involvement. A direct employee may have limited involvement with the beneficiary's care team, while appropriately supervised contracted personnel may be fully integrated into the practice's clinical workflow.

The proposal also affects practitioners differently because Medicare's "incident to" rules do not permit clinical staff to furnish services incident to an SLP. An SLP must personally furnish the qualified health care professional services represented by the applicable RTM treatment-management codes. ASHA requests that CMS confirm that the proposed direct-employment requirement applies only when a billing practitioner seeks to count clinical staff time and does not restrict an SLP or other qualified health care professional from personally furnishing and reporting RTM services.

CMS also should consider whether appropriately contracted clinical staff could satisfy the policy when the billing practitioner maintains documented responsibility for the treatment plan, supervision, data review, clinical decision making, and coordination of care. These safeguards would address CMS' concerns more directly than employment status alone.

Valuation of RTM Services

ASHA is concerned that CMS' proposed PE crosswalks may not accurately reflect the technologies and clinical workflows associated with RTM. RTM may involve software licensing, patient access to digital platforms, secure data transmission, technical support, patient onboarding, and integration of monitoring data into the clinical record. These resources may differ substantially from those associated with self-measured blood pressure or external cardiac event monitoring, which CMS proposes to use as crosswalks.

CMS acknowledges that it lacks sufficient information about the devices, software, workflows, and prices associated with these services. In the absence of adequate data, CMS should not assume that the existing RTM codes are overvalued. Before finalizing the proposed crosswalks or eliminating direct PE inputs from the RTM treatment-management codes, CMS should:

- evaluate RPM and RTM costs separately;
- identify the specific PE inputs that would be removed or replaced;
- account for software, licensing, data transmission, and platform costs in addition to physical devices; and
- consider current invoices and information about typical SLP RTM workflows.

ASHA urges CMS to retain the existing PE inputs until it has sufficient data to demonstrate that the proposed changes more accurately reflect the resources required to furnish RTM.

Potential Bundled HCPCS G-Codes

CMS is considering four HCPCS G-codes that would consolidate the existing RPM and RTM codes into separate setup and monthly monitoring codes. ASHA appreciates CMS' interest in

reducing administrative burden and ensuring that beneficiaries receive appropriate treatment-management services. However, replacing the existing code structure with bundled G-codes could reduce reporting flexibility and create new administrative complexity.

Under the contemplated structure, all elements of the monthly G-code—including device supply, data transmission, treatment management, and real-time interaction—would be required during the same calendar month. A beneficiary may not require every component during every month, and factors outside the practitioner's control, including the beneficiary's ability to transmit data, could prevent satisfaction of every requirement. Conditioning payment on completion of the entire bundle could leave medically necessary services uncompensated even when they were appropriately furnished.

CMS cites an Office of Inspector General (OIG) finding that approximately 43% of beneficiaries receiving RPM did not receive all three components of remote monitoring. That finding should be interpreted cautiously when considering changes to RTM. The OIG analysis concerned RPM, and Medicare's existing policy does not require every beneficiary to receive or have claims submitted for all three components in every period. The absence of a claim for one component therefore does not, by itself, demonstrate improper billing or inadequate care.

Recommendations

ASHA urges CMS to:

- finalize the established-patient requirement for RTM;
- confirm that an appropriate Medicare-covered evaluation furnished by an SLP may serve as the initiating visit;
- clarify that the direct-employment requirement applies only to clinical staff time and does not restrict RTM services personally furnished by an SLP or other qualified health care professional;
- refrain from reducing RTM PE inputs until CMS has sufficient RTM-specific cost and workflow data; and
- retain the existing CPT coding structure rather than creating bundled RTM G-codes.

(62) Caregiver Training Services (CTS)

CMS seeks comments on whether the resources required to furnish direct-care caregiver training services are appropriately recognized through HCPCS codes G0541, G0542 and G0543 or are already included in payment for other Medicare services, such as evaluation and management (E/M) visits. ASHA urges CMS to maintain separate coding and payment for medically necessary caregiver training that requires dedicated clinical work and is not duplicative of another billed service. Because SLPs cannot bill E/M codes under Medicare, incorporating these resources into E/M payment would leave SLPs without an appropriate means of reporting and receiving payment for these services.

HCPCS codes G0541, G0542, and G0543 describe direct-care training intended to help caregivers support patients with ongoing conditions and reduce complications. These services are distinct from the caregiver training reported under CPT codes 97550, 97551, and 97552 as part of a therapy plan of care. For example, an SLP may train a caregiver to clean and monitor a stoma or tracheoesophageal puncture, recognize leakage or prosthesis malfunction, and take appropriate steps to prevent aspiration, infection, and other complications. This training requires

separate clinician time and expertise that is not captured through an E/M visit or another billed service.

Therefore, ASHA urges CMS to continue separate coding and payment for G0541, G0542, and G0543. Subsuming these services into E/M payment would create a payment gap for services furnished by SLPs and could limit beneficiaries' access to training that helps caregivers prevent complications and safely support care in the home.

Section II.E. Request for Information: Redesigning Primary Care to Make America Healthy Again

CMS' efforts to improve access to care, as articulated in this RFI, are laudable. However, moving beyond a system of "sick care" requires multidisciplinary care teams rather than a focus on primary care alone. Consistent with the administration's prevention and wellness model, ASHA supports early, holistic attention to upstream drivers of improved outcomes and lower costs including communication, hearing, cognition, and swallowing. Innovative approaches that recognize therapy services as value generators rather than cost centers can reduce complications, improve function, support safe and timely discharge, improve adherence, and avoid downstream utilization.

Audiologists and SLPs Play a Vital Role in Prevention and Wellness

Audiologists and SLPs do not merely treat deficits; they work to prevent communication and hearing disorders, when possible, reduce their impact, and support optimal functioning across the lifespan. These professionals contribute to:

- **Primary prevention:** Eliminating or reducing risk so a disorder does not develop—for example, reducing exposure to risk factors or strengthening protective ones;
- **Secondary prevention:** Performing early detection and intervention to stop or slow the progression of a disorder in its initial stages; and
- **Tertiary prevention:** Reducing the disability or residual impairment that remains after a disorder has manifested through rehabilitation and maximizing functioning.

Including and incentivizing comparatively low-cost interventions provided by audiologists and SLPs can help delay or prevent higher downstream costs. As the U.S. population ages and the burden of chronic disease grows, strengthening social connections and psychological well-being—including purpose, optimism, and social support—offers a promising, evidence-based strategy to prevent disease and promote resilience in older adults. Research suggests that quality of life in older adults depends not only on physical health but also on meaningful social connections, which may be valued as highly as health itself.

Communication disorders can severely disrupt these essential connections between patients, their communities, and their natural environments. These conditions vary in type and severity and may occur with other symptoms that limit mobility, vision, endurance, or cognition. Early access to hearing and communication services improves a patient's ability to share and receive essential health information and maintain the social connections that support their well-being as they age. Audiologists and SLPs also help patients and health care providers communicate clearly and accurately using the methods that work best for them.

Without effective communication, all care can become low-value care. Effective communication can:

- improve diagnostic accuracy;
- help patients understand treatment options;
- ensure informed consent;
- support decision-making;
- increase adherence to care recommendations;
- enhance patients' autonomy and participation in care;
- reduce hospitalizations, lower length of stay, and reduce morbidity;
- help patients achieve oral (PO) feeding and reduce the risk of aspiration pneumonia by addressing dysphagia and feeding disorders; and
- assist patients and families in maximizing and/or compensating for impaired cognitive functions such as attention, memory, problem-solving, reasoning, and executive function.

Audiologists and SLPs contribute to prevention and wellness in several settings. For example:

- **School settings:** Audiologists partner with schools to monitor classroom acoustics and support learning environments conducive to clear speech perception. SLPs provide teachers and parents with language-stimulation strategies, particularly for students with mild risk factors such as fluctuating hearing loss or speech sound delay.
- **Community awareness campaigns:** Audiologists conduct public education about the risks of loud music and recreational noise, the appropriate use of earbuds, and the consequences of untreated hearing loss among older adults.
- **Health care settings:** Audiologists screen for noise-induced hearing loss and other hearing concerns. SLPs incorporate communication-risk assessments into care for health conditions such as stroke and dementia to identify concerns early.

Opportunities to Take a Holistic Approach to Redesigning Care

In reviewing the RFI, ASHA identified several issues for CMS' consideration.

Use of Artificial Intelligence

CMS notes that generative and agentic artificial intelligence (AI) are poised to transform both beneficiary experience and the role of primary care clinicians. Clinicians across specialties—not only those furnishing primary care—are using AI in a variety of ways. Patients are also using these tools to access health information and locate health care providers, including audiologists and SLPs. Models of care should preserve appropriate access to services regardless of whether a patient accesses a practitioner directly or through referral, consistent with applicable Medicare requirements.

While AI may reduce paperwork and delays, it can also cause serious harm when it overrides or interferes with individualized clinical judgment or access to care determinations. Therefore, it is essential to keep qualified humans meaningfully involved in decisions that affect patient care. Without strong guardrails and transparency requirements, the benefits of AI may not outweigh the risks. We urge CMS to take a balanced approach that supports appropriate innovation while maintaining strong protections to safeguard patients and preserve access to care.

ASHA urges CMS to establish standards for transparency and public disclosure of AI use, including information about underlying datasets, training protocols, algorithm validation, adherence to clinical guidelines, and known limitation or biases. This information should be presented in an easily accessible and understandable manner. Patients and providers should

also have a meaningful opportunity to appeal adverse determinations involving AI and obtain review by a qualified human representative of the payer.

Prospective Primary Care Payments (PPCPs)

Prospective primary care payment models show promise, but CMS's discussion of previous demonstrations indicate that many unresolved issues remain. For example, while Medicare expenditures grew more slowly for the PPCP group than for the comparison group, but the difference was not sufficient to offset care management fees. The models also did not appreciably improve or worsen physician or beneficiary experience or practice performance on the included claims-based quality measures.

Additionally, ASHA would argue that these models cannot be successful without including all members of multidisciplinary care teams. CMS should proceed cautiously with expansion of such models given these limitations.

*E*ffectiveness of Multidisciplinary Care Teams

In the RFI, CMS highlights a 2021 National Academies of Sciences, Engineering, and Medicine report, *Implementing High-Quality Primary Care*. The report reinforces the importance of team-based care. ASHA is concerned that focusing too narrowly on services furnished by primary care clinicians could overlook other members of the care team whose services are necessary to achieve the quality, outcomes, and savings CMS seeks.

Audiologists and SLPs should be included in multidisciplinary teams when clinically appropriate. Primary care models should support timely referrals, information sharing, and coordination with these professionals rather than treating their services as ancillary costs.

Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule

CMS expresses interest in capturing the work and value associated with longitudinal care relationships, which may require additional time, coordination, and resources. CMS also notes its longstanding concern that existing work RVUs as they do not fully capture the typical non-face-to-face care management work required for certain categories of beneficiaries (78 FR 43337).

Longitudinal care relationships are not limited to primary care. SLPs often provide services on an episodic or long-term basis as a patient's needs evolve. Following a stroke, for example, an SLP may initially evaluate and treat dysphagia to support safe nutrition and hydration. At the next level of care, the SLP may address aphasia so the patient can communicate wants and needs with family members and caregivers. After discharge, the patient may require additional services to address the communicative and cognitive demands of resuming family, community, or work responsibilities. Throughout this continuum, the SLP addresses communication, cognition, and swallowing to maximize functional independence and reduce preventable complications.

This reinforces the importance of valuing long-term health care relationships between patients and their clinical care teams beyond primary care.

Payment Implications of Technology Enablement of Primary Care

CMS states in the proposed rule that it is its understanding is that clinical documentation and clinical decision-support tools are currently the most commonly used applications of AI in primary care. Does this reflect current practice? In particular, are there additional clinical AI tools and new technologies that are frequently being used in primary care settings with high accuracy, demonstrated safety, and clinical outcomes reported? If so, please describe how they impact the clinical workflow and the beneficiary experience.

AI has numerous applications across:

- the health care space, including referrals and appointment scheduling;
- patient care, including evaluation and treatment decision support tools;
- documentation, including AI scribes, billing, coverage determinations, quality measurement, and population health.

If you are a physician furnishing primary care services, how has your practice been impacted or how do you expect it will be impacted by clinical AI tools?

AI should be viewed as a helpful technological tool rather than an autonomous decision-maker. Clinicians remain responsible for evaluating AI-generated information, ensuring accuracy, protecting patient privacy, and exercising professional judgment. AI can enhance clinicians' efficiency, but it cannot replace the expertise, empathy, and accountability that define high-quality audiology and speech-language pathology services.

Like every technology, AI has limitations. One of the most well-known challenges is hallucination, where an AI system generates information that sounds convincing but is not accurate or could even be completely fabricated. We've all heard cautionary tales of hallucinated citations using real authors' names from hallucinated journals. AI may also reflect biases present in the data it was trained on. For example, if historical utilization data for different populations was used to train a tool, it could predict that marginalized populations require less care due to historical access and equity issues. That is a false but logical conclusion given the data it was trained on. It may miss important contextual information, misunderstand complex clinical situations, or produce generic responses that don't accurately reflect an individual patient or student.

*Primary Care Capitated Payment Arrangements Consi*derations for the Shared Savings Program

ASHA does not oppose capitated payment arrangements if they are constructed carefully. These models should provide adequate payment, incorporate appropriate risk adjustment for beneficiaries with chronic or complex patients, and avoid penalizing clinicians for outcomes beyond their control. CMS should include comprehensive outcome measures and prevent payment from inadvertently disincentivizing referrals to medically necessary audiology and speech-language pathology services.

Section II.G.2. Request for Information on Community-Based Palliative Care

ASHA appreciates CMS' efforts to clarify coverage of palliative care through proposals included in the CY 2027 Home Health Prospective Payment System proposed rule, the CY 2027 MPFS proposed rule, and the fiscal year 2027 hospice proposed rule. Audiologists and SLPs provide palliative care services as members of interdisciplinary care teams in a variety of settings.

While CMS highlights the role of physicians in providing this type of care through E/M and care management services, Medicare does not authorize audiologists and SLPs to bill these services. Therefore, CMS should consider the full range of care models and CPT codes used to bill medically necessary palliative care, particularly as the CMS Innovation Center reports emphasize the importance of interdisciplinary care teams. Any future palliative care model should recognize the contributions of all qualified members of the care team and ensure that medically necessary audiology and speech-language pathology services are appropriately reportable and payable.

Audiologists can play an important role in palliative care by preserving communication, autonomy, comfort, and social connection for people with hearing loss. Hearing difficulties can interfere with a patient's ability to understand discussions about treatment and end-of-life preferences, answer questions about pain and symptoms, and participate meaningfully in decisions about their care. Hearing loss may also be mistaken for cognitive impairment, potentially leading clinicians or family members to underestimate a patient's ability to participate. Addressing hearing needs therefore supports person-centered palliative care by helping patients communicate their needs, remain engaged in care planning, and participate more fully in counseling, spiritual care, and meaningful conversations with family and friends.

Audiologists' contributions can include evaluating hearing, ensuring hearing aids function appropriately, and recommending assistive listening technologies or personal amplification devices. Audiologists can also help patients, families, and palliative care teams implement communication strategies, such as reducing background noise, speaking face-to-face at eye level, gaining the patient's attention before speaking, and supplementing spoken communication with written information when needed. Interventions such as cleaning or repairing a hearing aid or providing an amplification device may substantially improve the patient's ability to describe pain, understand clinicians, participate in decisions, benefit from psychosocial or spiritual services, and communicate with loved ones during the final stage of life.[5]

SLPs also provide palliative care services that support safe and comfortable eating and drinking and help facilitate communication and decision making for patients with communication, cognitive, or swallowing impairments.[6] SLP interventions may focus on improving quality of life, reducing symptoms, and delaying or managing worsening symptoms.[7] As one study noted, the SLP involvement in palliative care "empower(s) the patient with strategies so that they can autonomously and self-determinedly express their experiences and most significant needs."[8]

Eligibility for Serious Illness Care

1. **For any future supportive or palliative care service for Medicare beneficiaries, should eligibility be restricted to certification of a likely life expectancy duration?**

   No. As noted in the CY 2027 home health proposed rule, palliative care is defined in the code of federal regulations at § 418.3 to mean ''patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.''

   Although palliative care is often associated with hospice care, the two are distinct. Palliative care may be appropriate throughout the course of a serious illness. Therefore,

ASHA does not recommend restricting eligibility based on certification of a particular life expectancy.

2. If eligibility is restricted to those beneficiaries with a terminal prognosis, is there evidence to suggest a reasonable interval (that is, less than 1 year of life expectancy as in some States' Medicaid programs)?

As noted in the home health prospective payment system proposed rule, coverage of palliative care is allowed because the primary criteria are that the palliative care services delivered require the skills of the clinician providing the service and that the service is designed to improve or maintain function for the patient. This same coverage criteria exists for services paid under the physician fee schedule. Part B coverage is also predicated on the services being designed to treat an illness or an injury. As palliative care is designed to be skilled, treat an illness or injury, and improve or maintain function for the patient, eligibility should not be restricted to terminal prognosis or a specified timeframe.

Eligibility for Palliative Services

1. **For any future supportive or palliative care service for Medicare beneficiaries, how could we consider impact on the daily functions of life or activities of daily living as part of who is eligible for the service?**

   As CMS considers eligibility for palliative care services, it should consider the following:

   - Eligibility should not be limited to a fixed list of diagnoses. Condition-specific criteria (cancer, Parkinson's, ALS) or conditions that have an expected duration of more than six months, for example, that may or may not be considered terminal illnesses can warrant use of palliative care services.
   - A comprehensive functional assessment of physical, cognitive, hearing, communication, and swallowing abilities is critical. Aligning reporting across practice settings helps patients more effectively understand and compare their treatment options and reduces reporting burden for palliative care providers. CMS could consider leveraging existing functional assessment domains from the Improving Post-Acute Care Transformation (IMPACT).
   - Caregiver needs and available support should be considered. SLPs have expertise in caregiver training to help improve outcomes for patients and reduce caregiver strain.

2. **Would eligibility best be based on impact on daily function, on caregiver strain, or both?**

   Both daily function and caregiver strain should inform eligibility, but neither should operate as an inflexible prerequisite. Functional limitations directly indicate the beneficiary's need for palliative services, while caregiver strain may demonstrate that existing supports are insufficient to meet those needs safely. Because beneficiaries differ in their functional abilities, living arrangements, and available caregiver support, either factor—or a combination of both—should be sufficient to establish the need for services.

ASHA underscores the vital importance of comprehensive functional measures to accurately capture a patient's full range of functional status, including hearing, communication, swallowing, and cognitive function. Failure to capture holistic functional status leaves beneficiaries and their families vulnerable to significant risks and avoidable increased costs to Medicare. Accurately measuring these domains of function for patients will capture potential hinderances to social interaction and its downstream effects on well-being.

3. **How can we avoid overly burdensome requirements for defining eligibility for services?**

   Coverage of any service should always be focused on the needs of the patient and the interventions implemented to address those needs. Creating additional or special criteria has the potential to exclude patients who could benefit from palliative care or unnecessary confusion about whether a patient qualifies for these services.

The Future of Care Management Services

1. **How should we differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries?**
   Care management is a critical component of value-based care as it helps ensure that beneficiaries receive the right services at the right time and in the most appropriate setting. Effective care management can reduce fragmentation, identify needs before they escalate, support adherence to treatment plans, and improve coordination across providers and settings. These functions can help prevent avoidable emergency department visits, hospitalizations, readmissions, and other high-cost utilization while supporting better outcomes.

   Care management can also connect beneficiaries to rehabilitation, behavioral health, social supports, and other services that address functional needs and barriers to successful treatment. As value-based models increasingly hold providers accountable for both quality and total cost of care, robust care management provides an important mechanism for achieving savings through better coordination and prevention rather than through restricting access to necessary services.

   Importantly, the benefits of care management should not be limited to beneficiaries who meet narrow definitions of high risk or who have already experienced significant health complications. All beneficiaries can benefit from support navigating an increasingly complex health care system, coordinating services across providers, understanding treatment recommendations, and identifying emerging needs.

   A broader approach to care management can support prevention and early intervention across the continuum of care, including primary, secondary, and tertiary prevention. Making care management available based on individual needs—rather than solely on diagnoses, utilization history, or predicted costs—can help value-based care models identify problems earlier, preserve function and independence, improve beneficiary experience, and prevent individuals from becoming high-cost patients in the first place.

2. **What are the essential service elements that must be included? For example(s), continuity with a designated team member, access to timely clinical support,**

comprehensive symptom and caregiver assessment, electronic care plans, coordination with treating physicians, patient/caregiver education, timely follow up after ED/discharge. What other service elements should be included? Should any not be included?

Audiologists and SLPs provide many of these types of services, including establishing communication access, conducting comprehensive and caregiver assessments within their scopes of practice, developing plans of care, coordinating services across multidisciplinary care teams, and providing patient and caregiver education. These are all critical elements of palliative care and, as such, should be included in any benefit when provided by any member of the multidisciplinary care team within their respective scope of practice.

Section II.G.3. Request for Information on Intensive Lifestyle Intervention to Slow Progression of Alzheimer's Disease

1. **Given the discussion of the evidence to date on the effectiveness of intensive lifestyle interventions for CMS to pursue, we are particularly interested in demonstrations of cost-savings associated with these and other interventions. Please cite any evidence available in your discussion.**

   SLPs are experts in treating patients with communication and cognitive-communication deficits associated with a variety of clinical conditions, including Alzheimer's disease. Addressing these domains is a practical prerequisite for social engagement and for participating in and adhering to the type of multidomain lifestyle intervention CMS envisions. Helping patients with Alzheimer's disease engage with their communities and participate effectively in their plans of care helps avoid downstream costs associated with depression from social isolation or hospitalizations.

   SLPs are often able to identify early signs of cognitive decline that may ultimately be associated with an Alzheimer's disease diagnosis. Interventions provided at the earliest onset of changes in communication and cognitive-communication abilities can help patients improve or maintain function. SLPs develop plans of care that address word-finding difficulty, impaired discourse, reduced attention, difficulty following conversations, and reduced problem solving that may limit a person's ability to participate in family, community, group, and health-management activities. These barriers may arise before or alongside formal cognitive impairment and can contribute to withdrawal from social activity.

2. **Given CMS' concern for addressing fraud, waste, and abuse throughout the Medicare program, please comment on any potential or observed FWA in diagnosis, treatment, or management of AD/ADRD.**

   As CMS notes in the request for information, addressing hearing loss is critical in the prevention, identification, and treatment of Alzheimer's disease. Medicare has imposed a regulation that requires a physician order for a hearing or balance assessment service provided by an audiologist to be covered. Many other payers and most states do not require a physician order before an audiologist provides an assessment. This makes Medicare an outlier compared to other payers and creates an additional barrier to care that patients with other forms of insurance may not experience.

In many instances, patients must visit a physician solely to obtain the order, creating unnecessary costs and scheduling burdens for patients and the Medicare program. An analysis of the fiscal impact of legislation that would improve Medicare beneficiaries' access to audiology services found that eliminating the physician order requirement would create significant savings for beneficiaries and the Medicare Trust Fund.

Available data do not indicate that requiring a physician order before hearing and balance assessment services meaningfully improves safety or program integrity. For example, malpractice data does not demonstrate a high risk of safety or compliance concerns when audiologists provide services. The malpractice expense relative values associated with CPT codes typically used by audiologists are among the lowest of the for clinical professionals eligible to bill Medicare. CMS' data also show that audiologists spend less than $300 annually, on average, for malpractice insurance. Additionally, according to the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology, since 1992, very few audiologists have had a health plan action taken against them, 14 have had a judgment or conviction, 72 have made a malpractice payment, and only 381 have had a state licensure action imposed on them. These data indicate that services provided by audiologists are often low-risk and present few safety concerns for Medicare beneficiaries.

In short, requiring a physician order for an audiologic assessment furnished by an audiologist can waste patient's time and money and increase Medicare spending for the Medicare with no associated benefit. Therefore, ASHA continues to request that CMS eliminate this unnecessary administrative burden for patients, physicians, and audiologists.

3. **Given the emerging role of biomarker diagnostic testing (for example, p-tau217, et. al) for AD/ADRD leading to early diagnosis, please provide any evidence supporting earlier detection and its role in supporting improving AD/ADRD care and any potential role in identifying eligibility for an intensive lifestyle intervention focused on AD/ADRD.**

   Although biomarker diagnostic testing is an important tool in identifying Alzheimer's disease, evidence also supports the role of SLPs who are uniquely qualified to use their skill sets in the early identification of these patients as well. For example, a report published by the National Institute of Aging, identifies subtle changes in speech that may be associated with early signs of the disease.[9] These findings are reinforced by research produced by the University of Pennsylvania Penn Memory Center.[10]

   SLPs may also identify changes associated with executive functioning skills, such as a patient's ability to manage their doctor's appointments or medication schedule. CMS should always maintain a comprehensive toolkit for the identification and treatment of Alzheimer's disease and related dementias that includes promising technological advancements, such as biomarker testing, as well as the tried and true clinical expertise of multidisciplinary care teams.

5. **Should these interventions be made available as a one-time service (that is, to teach older adults how to make changes in their lifestyle to help reduce AD/ADRD risk) or on a recurring (for example, annual) basis?**

Ongoing surveillance of patients over 65, particularly those with a family history of Alzheimer's disease or related dementias, is critical for early identification and effective care planning. Timely interventions to help patients and caregivers establish and maintain compensatory strategies for critical health care executive functioning processes, such as managing medications and scheduling appointments, before significant progression of the disease.

At a minimum, patients should be assessed annually for signs of communication and cognitive-communication changes and promptly referred to a SLP to establish a baseline and a plan of care that incorporates the patient's goals. Routine screening and engagement help reduce stigma, which can be a critical barrier to identifying Alzheimer's disease and related dementias.

6. Should the eligibility for these services be restricted to beneficiaries with a diagnosis of mild cognitive impairment (MCI), or early-stage dementia? If so, how should this diagnosis be made or confirmed?

ASHA does not believe eligibility should be restricted to beneficiaries with MCI or early-stage dementia because evidence of cognitive decline may be present, but unrecognized, prior to such a diagnosis. However, these diagnoses should also serve as triggers for considering preventative care because the research shows that SLPs can still help to prevent or slow progression. Research consistently demonstrates that early intervention is important and beneficial.[11]

7. Given ILI's are multi-domain, and likely include physical activity, nutrition, and potentially additional domains such as sleep and stress management, who are the essential interdisciplinary team members that CMS should account for in developing appropriate resource costs for future services?

Changes in communication, cognition, and hearing may be early signs of Alzheimer's disease and related dementias and may affect a beneficiary's ability to participate in an intensive lifestyle intervention. Therefore, CMS should include audiologists and SLPs among the clinical professionals on multidisciplinary care teams when appropriate.

8. How should supervision be determined for AD/ADRD ILI's? Is general supervision sufficient for ensuring clinical safety and oversight? Is direct supervision required?

Audiologists and SLPs are authorized under state law to provide care without supervision. Under Medicare, audiologists and SLPs are eligible to independently enroll in and bill Medicare for services they provide. Additional physician supervision or oversight is not required under state law or Medicare regulation.

10. Should CMS require a future AD/ADRD ILI to be delivered in person? Can it be delivered virtually?

As demonstrated by the inclusion of the vast majority of audiology and speech-language pathology services on the authorized telehealth services list, the interventions these clinicians provide to patients across the lifespan and clinical condition, including dementia, can be provided either in-person or via telehealth.

Section II.H. Request for Information on Current Procedural Terminology

ASHA supports continued evaluation of the Current Procedural Terminology (CPT®) and Relative Value Scale Update Committee (RUC) processes to enhance transparency, accessibility, representation, and the accuracy of Medicare payment. ASHA also recognizes CMS' critical responsibility to protect Medicare beneficiaries and safeguard the Medicare Trust Funds. This RFI provides an important opportunity to examine both the challenges and opportunities associated with the current CPT code development and valuation processes.

Although the participation of specialty societies is characterized in this RFI as presenting an inherent conflict of interest, it is equally important to recognize the essential expertise and infrastructure these societies contribute to accurate coding, valuation, and billing practice—functions that would be difficult to replicate. Specialty societies such as ASHA identify changes in clinical practice, develop and refine code proposals, survey practicing clinicians, provide evidence regarding the time and resources required to furnish services, and educate clinicians on the appropriate implementation and reporting of new and existing codes. These activities require substantial clinical and technical expertise, dedicated staff, financial resources, and significant investments of time that could not immediately be replaced.

1. **What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA'S monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.**

   ASHA recognizes that there are challenges associated with the current CPT licensing model, including licensing and royalty fees incurred by health care organizations, electronic health record vendors, software developers, payers, and other entities that rely on CPT. These costs may ultimately be passed through the health care system and contribute to administrative expenses that can indirectly affect providers and patients. However, regardless of the entity responsible for developing or maintaining CPT codes—whether the AMA, CMS, a nonprofit organization established to manage the process—the costs associated with compliance and administration would not be fully eliminated.

   ASHA also believes there are opportunities to improve the AMA CPT code development process and continue to enhance the development and valuation of codes. One area of concern has been a lack of transparency in the process. However, in recent years, the AMA has taken meaningful steps to address these concerns by opening CPT Editorial Panel meetings to interested parties and posting publicly available minutes and summaries on its website.

   Despite these concerns, ASHA is not aware of evidence demonstrating that the AMA's stewardship of CPT has directly delayed improvements in patient care or inhibited clinical innovation. The CPT process has evolved to accommodate advances in medicine, technology, and clinical practice through a structured, evidence-based, multispecialty process. Specialty societies play a critical role by identifying emerging and evolving services and providing the clinical expertise and evidence necessary to ensure that innovations in clinical care are appropriately recognized within the CPT code set and accurately valued through the RUC process.

Concerns regarding the CPT process should also distinguish CPT code development from payer coverage and payment policies. The CPT process is designed to describe and recognize clinical services based on clinical practice and evidence, independent of individual payer policies, including those of Medicare. Although the AMA administers the CPT code set and the RUC develops valuation recommendations, **CMS and other payers retain final authority** to determine whether services are covered and how they are valued and paid. CMS may reject RUC-recommended values or establish different coding structures, such as HCPCS G codes, when the agency determines that doing so is appropriate. This public oversight provides an important balance within the current system.

Although improvements in transparency, efficiency, and accessibility should continue to be explored, ASHA believes any consideration of replacing or substantially restructuring the CPT system should be approached with great caution. CPT is deeply integrated throughout the U.S. health care system, including Medicare, Medicaid, commercial insurance, electronic health records, quality reporting programs, research, and health care analytics. A transition to an alternative coding infrastructure would require significant financial investment, technical resources, staffing, and ongoing maintenance.

Before pursuing such a transition, CMS should carefully evaluate whether it has the operational capacity and resources necessary to develop, maintain, update, educate stakeholders on, and govern a national procedural coding system. Most importantly, any changes must avoid disrupting provider reimbursement, administrative operations, or beneficiary access to care. In ASHA's view, strengthening the existing collaborative CPT process is likely to achieve greater benefits than replacing it with a new system that could introduce significant uncertainty and unintended consequences.

2. **What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?**

ASHA believes it is important to distinguish between the development of **CPT codes** and the determination of **medical necessity**, as these are separate but complementary components of the health care payment system. The primary purpose of the CPT Editorial Panel is to determine whether a procedure or service developed to treat an illness or injury is sufficiently established, distinct, and supported by clinical evidence to warrant a unique procedural code. CPT code development focuses on accurately describing the service performed, rather than determining the clinical circumstances under which the service should be covered. Medical necessity is appropriately established through the patient's diagnosis, clinical presentation, evidence-based practice guidelines, and payer coverage policies, using diagnosis codes such as ICD-10 in conjunction with the reported CPT code.

Although the CPT process is not intended to make coverage determinations, the development of new CPT codes is grounded in clinical evidence and accepted medical practice. The CPT Editorial Panel requires supporting documentation, including peer-reviewed literature, evidence of widespread clinical use, and input from multidisciplinary clinical experts before creating or revising a code. Similarly, the AMA RUC evaluates the physician or qualified health care professional work, time, intensity, and practice resources required to furnish the service. These processes help ensures that CPT codes represent clinically valid, evidence-based procedures, while allowing CMS and other payers to

independently determine whether those services are medically necessary for individual patients.

ASHA does not recommend incorporating formal medical necessity determinations into the CPT code development process. Doing so would fundamentally change CPT from a procedural coding system to a coverage determination process, creating duplication with existing payer responsibilities and potentially slowing innovation by delaying recognition of new procedures and technologies. Instead, CMS should continue to rely on the complementary roles of CPT and ICD-10: CPT should describe **what** service was performed, while ICD-10 and applicable coverage policies help establish **why** the service is medically necessary. This separation has allowed the coding system to evolve alongside advances in medicine while preserving flexibility for Medicare and other payers to make evidence-based coverage decisions as new clinical evidence emerges.

3. **A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002(a)(5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?**

   ASHA is not aware of any currently available alternative that could replace CPT as the national coding standard for physician and other qualified health care professional services. Although advances in health information technology, artificial intelligence, and clinical terminologies offer opportunities to improve health care delivery, other terminologies and classification systems were designed for different purposes and can supplement, but not replace, CPT.

   For example, Systematized Nomenclature of Medicine Clinical Terms (**SNOMED CT**) is an internationally recognized clinical terminology that provides a standardized method for documenting diseases, clinical findings, procedures, and patient outcomes. It plays a critical role in supporting electronic health records, interoperability, clinical decision support, quality measurement, research, and artificial intelligence. However, SNOMED CT was designed to describe **what clinical care was provided**, not **how health care services should be valued or paid**.

   Unlike the AMA CPT and RUC processes, SNOMED CT does not capture all the elements necessary to establish appropriate Medicare payment, including physician or qualified health care professional work, professional time, cognitive effort, clinical complexity, mental effort, practice expense, malpractice expense, resource utilization, global periods, multiple procedure relationships, or add-on services.

   Allowing multiple completing procedural code sets without a uniform national standard could increase—not reduce—administrative burden. Supplementary terminologies may support more detailed clinical documentation and data exchange, but they should be reliably mapped to a uniform national coding standard. Any change to the HIPAA standards for national coding requirements should proceed through appropriate rulemaking and include extensive testing, stakeholder input, implementation planning, and protections against disruption to claims payment or beneficiary access.

4. What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?

CMS should distinguish between the CPT process, which creates and maintains procedure codes, and the RUC process, which develops recommendations regarding the relative resources associated with services. Although related, these processes address different questions and should not be evaluated as a single decision-making structure.

Objectivity can be strengthened without discarding the clinical expertise provided through CPT and the RUC. Potential improvements include:

- greater transparency regarding decision criteria, evidence considered, and the reasons for final recommendations;
- consistent disclosure and management of potential conflicts of interest;
- meaningful representation of nonphysician practitioners and other qualified health care professionals;
- continued publication of meeting summaries, recommendations, and supporting rationales;
- use of multiple data sources, including clinician surveys, Medicare claims, time studies, cost data, and other empirical information; and
- a clear process for reconsidering codes or values when new evidence becomes available.

The RUC HCPAC provides an established mechanism for audiologists, SLPs, and other nonphysician practitioners to participate in developing relative-value recommendations for services they principally furnish. CMS should build on this structure and ensure that nonphysician perspectives receive meaningful consideration throughout code development and valuation.

Independent data collection and external expert review can supplement CPT and RUC recommendations. However, removing practicing clinicians and specialty societies from the process would risk producing codes and values that do not accurately reflect how services are furnished. A wholesale replacement could also delay new codes, fragment the coding system, and inhibit innovation. The preferable approach is to retain clinical expertise while strengthening transparency, representation, empirical validation, and CMS' independent review.

5. What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

ASHA appreciates CMS' interest in exploring alternative approaches to coding and payment under the Medicare Physician Fee Schedule. However, we do not believe that the

International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes or the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) are appropriate alternatives to CPT for determining payment for physician and other qualified health care professional services.

These coding systems were designed for fundamentally different purposes. ICD-10-CM codes identify **why** a patient requires care and are essential for establishing medical necessity, risk adjustment, quality reporting, public health surveillance, and research. CPT codes identify **what** service was performed and provide the foundation for resource-based payment by reflecting the professional work, time, clinical complexity, practice expense, technology, and malpractice costs associated with furnishing a service. A diagnosis alone cannot distinguish the type, intensity, duration, or resources required for treatment. For example, a patient with aphasia may receive a brief treatment session, a comprehensive evaluation, caregiver training, or augmentative and alternative communication device programming. Although these services may be associated with the same diagnosis, each requires substantially different professional expertise and resources.

Similarly, ICD-10-PCS is not an appropriate alternative for physician payment because it was developed specifically to classify inpatient hospital procedures rather than professional services furnished under the Medicare Physician Fee Schedule. Grouping physician services using ICD-10-PCS categories or hospital payment methodologies such as Medicare Severity Diagnosis Related Groups (MS-DRGs) or Ambulatory Payment Classifications (APCs) would not accurately reflect the work, complexity, time, or resources associated with individual physician and qualified health care professional services. Such an approach would reduce payment precision, diminish transparency, make it more difficult to recognize new technologies and evolving clinical practice, and limit CMS' ability to value innovative procedures accurately. It also would not allow CMS to effectively monitor utilization patterns because diagnosis codes cannot distinguish among the different services furnished to patients with the same condition.

Finally, ASHA notes that the international disease classification system continues to evolve independently of the U.S. physician payment system. Much of the world has already transitioned to **ICD-11**, while the United States continues to use ICD-10-CM and ICD-10-PCS. Additionally, recent changes in U.S. policy regarding participation in the World Health Organization create uncertainty regarding the future direction and governance of the ICD classification system. Building the Medicare Physician Fee Schedule around a diagnosis classification system that is developed and maintained for clinical and statistical purposes—not payment—and that continues to evolve internationally would introduce unnecessary complexity and uncertainty. Rather than replacing CPT, ASHA believes ICD-10-CM and CPT should continue to serve their complementary roles: ICD-10-CM identifies the patient's diagnosis and helps establish medical necessity, while CPT identifies the specific service performed and provides the basis for accurate valuation and payment. This approach best supports innovation, payment accuracy, and continued access to high-quality, evidence-based care.

Section III.G. Medicare Shared Savings Program

ASHA supports CMS’ proposed changes to the Medicare Shared Savings Program (MSSP) that would reduce financial barriers and improve beneficiaries’ access to value-based care.

ASHA strongly supports allowing eligible ACOs, under a CMS-approved implementation plan, to reduce or eliminate beneficiary cost sharing for certain Medicare Part B items and services. Coinsurance can create a significant barrier to medically necessary audiology and speech-language pathology services, particularly when an effective treatment plan requires multiple visits—which is common for these services. These cumulative costs may cause beneficiaries to delay care, discontinue treatment prematurely, or receive fewer services than clinically necessary.

Under the proposal, ACOs could determine which categories of Part B items and services qualify for cost-sharing support. ASHA urges CMS to confirm that covered audiology and speech-language pathology services are eligible and to encourage ACOs to include these services in their implementation plans. Eligibility for reduced cost sharing should be based on beneficiaries' clinical and functional needs and should not be limited to services furnished by physicians or primary care practitioners.

CMS should finalize the proposal with clear beneficiary communications, transparent and nondiscriminatory eligibility criteria, appropriate protections for patient choice, and operational guidance that allows ACOs and participating clinicians to implement the benefit without creating billing confusion. The agency should also evaluate which services and beneficiary populations receive cost-sharing support and whether this flexibility improves access, adherence, patient experience, and outcomes.

Section IV. CY 2027 Modifications to the Quality Payment Program Reporting and Data Submission

Transforming MIPS: MIPS Value Pathway Strategy

CMS proposes to fully transition to MIPS Value Pathways (MVPs) beginning with the CY 2029 performance year/2031 payment year. CMS highlights its progress in developing a range of MVPs that would capture 98% of MIPS reporters and its commitment to developing additional MVPs in time for a successful transition.

ASHA recognizes that MVPs can help facilitate the successful participation of clinicians in the Quality Payment Program, thereby improving the quality and value of care provided to Medicare beneficiaries. This is achieved by helping clinical specialties "package" the most relevant measures from each performance category: Quality, Promoting Interoperability, Improvement Activities, and Cost. However, many nonphysician specialties—including audiologists and SLPs—have no available cost measures, which limits their full participation in MVPs.

Despite efforts to engage in alternative payment models and quality reporting programs, as well as efforts to develop cost measures, none of the diagnosis or procedural codes representative of audiology or speech-language pathology services are included in the measure specifications, precluding its use by these clinicians. Additionally, cost measures are difficult to develop for clinical specialties that do not have the ability to control the total cost of care in the same way as many physicians.

Currently, CMS addresses this deficiency of the MVP structure to allow audiologists and SLPs and other clinical specialties without cost measures to redistribute the weight of the Cost performance category to another performance category, such as Quality. This maintains a pathway for participation in the QPP.

However, CMS's current MVP development policy requires an MVP to include at least one applicable cost measure. This requirement may present a barrier to developing a standalone MVP for audiology or speech-language pathology. Without addressing a challenge that affects these and many other specialties, it would be premature to transition fully to MVPs without establishing an alternative pathway for MVP development.

Participation in MIPS or MVPs remains a concern for audiologists and SLPs. Very few of these clinicians are currently required to participate in MIPS because of the low-volume threshold, and ASHA expects this will remain the case under MVPs. For audiologists and SLPs who opt in or are required to participate, the financial value of participation can be challenging. Positive MIPS payment adjustments have typically been relatively modest, below 3%, while administrative costs associated with compliance and reporting may offset much or all of that benefit. However, clinicians who are required to participate but fail to do so, face a substantially greater financial consequence: a negative 9% payment adjustment.

Transitioning fully to MVPs without establishing a pathway for specialties that lack an applicable cost measure would create a barrier to their expanded participation in value-based payment. Audiologists and SLPs who choose to participate—or who independently meet the criteria for mandatory participation—should have a fair, clinically relevant, and achievable pathway to not only successful participation, but also MVP creation. Audiologists and SLPs are best positioned to determine the potential cost-benefit of participation is appropriate given the associated administrative and financial burdens.

ASHA urges CMS to preserve the current low-volume threshold for MIPS participation and allow time for continued consideration of the optimal path forward that will avoid unintended negative consequences to audiologists and SLPs.

Quality Reporting

ASHA supports the proposed quality-reporting changes to address operational difficulties that ACOs have experienced in aggregating data across multiple taxpayer identification numbers and electronic health record systems. Extending existing reporting options and flat benchmarks, establishing Medicare electronic clinical quality measures as an additional collection type, and providing a phased pathway toward Fast Healthcare Interoperability Resources-based reporting are reasonable ways to support the transition without requiring every organization to move at the same pace.

CMS has identified circumstances in which uncertainty and reporting burden have affected ACO decisions about adding practices. The feasibility of quality reporting is therefore relevant not only to beneficiary access to value-based care but also to administrative efficiency.

Addition to the Audiology Quality Measure Specialty Set

ASHA values CMS' efforts to ensure audiologists have a robust quality measure set to through which they can demonstrate the efficacy of the services they provide and retain the flexibility they need to be successful QPP participants. However, we do not believe the proposed measure, "Age-Related Hearing Loss: Comprehensive Audiometric Evaluation," is appropriate for audiologists as currently structured.

Based on the specifications developed by the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), this measure seems to be designed to ensure that patients who

need a comprehensive audiometric evaluation receive an order or referral, or complete the evaluation, within four weeks.

Although audiologists are qualified to determine when an audiologic evaluation is clinically appropriate, Medicare generally requires an order from a physician or other authorized practitioner before the evaluation can be covered (AB modifier being the exception). Audiologists cannot independently issue the Medicare-required order. An audiologist may furnish the evaluation after receiving the order, but the audiologist does not control whether the referring practitioner issues that order within the measure's required timeframe.

Furthermore, the measure specifications limit reporting to only those providers eligible to bill E/M codes. Because CMS classification prevents audiologists from billing E/M codes, audiologists are structurally ineligible to report the measure. This makes the measure fundamentally inappropriate for inclusion in the Audiology Quality Measure Specialty Set as currently specified.

If the measure specifications were modified in specific ways, possibly through expansion of the AB modifier, it is plausible that the measure could be added as an option to the audiology specialty measure set in the future. The AB modifier allows Medicare-covered audiologists to bill certain diagnostic hearing tests without a physician or nonphysician practitioner (NPP) order — but only once per patient per 12-month period, and only for non-acute conditions. ASHA is committed to working with AAO-HNS and CMS to ensure the measure meets the needs of the patients they serve.

Section VII.D.1. Regulatory Impact Analysis: Conversion Factors and Effects of the Proposed Changes in Relative Values

Conversion Factor

ASHA remains deeply concerned that the MPFS continues to produce year-over-year payment reductions that threaten the long-term sustainability of audiology and speech-language pathology services and access to care for Medicare beneficiaries. Although the statutory updates for CY 2027 provide a 0.75% adjustment for qualifying alternative payment model (APM) participants and a 0.25% adjustment for clinicians who do not participate in a qualifying APM, these increases do not translate into meaningful payment growth for providers, particularly after the numerous legislative reductions applied to the fee schedule, such as sequestration and PAYGO. Most audiologists and SLPs do not participate in qualifying APMs and therefore receive only the 0.25% statutory update.

Moreover, any appearance of a positive update is overshadowed by the expiration of the temporary 2.50% conversion factor increase provided for CY 2026 under Public Law 119-21. Once that temporary relief expires, the combined effect of statutory requirements and other MPFS adjustments results in proposed CY 2027 conversion factors of $33.1693 for qualifying APM participants and $32.8409 for nonqualifying clinicians. These amounts represent reductions of 1.19% and 1.68%, respectively, compared with CY 2026.

In other words, **the statutory payment update does not represent a true increase in Medicare reimbursement**. Providers will receive less in CY 2027 than they did in CY 2026, even before accounting for changes to individual service-level RVUs. As a result of the lower conversion factor and proposed RVU modifications, audiologists could experience reductions of as much as 5%, while SLPs could face an approximately 1% reduction in payment rates.

Specialty Impact Analysis

As discussed in Section II.B, ASHA is concerned about the effects of CMS' proposed PE methodology changes on services furnished by SLPs. Those concerns are compounded by the absence of an SLP-specific estimate in CMS' specialty impact analysis.

In Table D-B5, CMS estimates that proposed changes to work, PE, and malpractice RVUs will result in an aggregate 3% increase in allowed charges for physical and occupational therapy services. This estimate reflects changes within the total RVU pool and does not include statutory conversion-factor updates that occur outside budget neutrality. CMS does not provide a corresponding specialty-level estimate for speech-language pathology services.[12]

The absence of a distinct speech-language pathology category makes it difficult for SLPs, employers, and other stakeholders to evaluate the combined effects of CMS' proposed coding, valuation, and PE policies. Speech-language pathology services involve different procedure codes, utilization patterns, treatment times, PE inputs, and malpractice expenses than physical and occupational therapy services. Accordingly, the aggregate estimate for physical and occupational therapy cannot reliably serve as a proxy for the effect on speech-language pathology services. ASHA's code-level analysis in Section II.B indicates that several speech-language pathology services would experience reductions in nonfacility PE RVUs, further demonstrating the need for a speech-language pathology-specific analysis.

This limitation is particularly consequential for CY 2027 because speech-language pathology services are simultaneously affected by the transition from CPT code 92507 to 10 new time-based codes, proposed valuation and MPPR policies, and broader changes to the PE methodology. Without a separate estimate, stakeholders cannot determine the aggregate effect of these interacting proposals or provide CMS with fully informed feedback.

ASHA has consistently urged CMS to recognize speech-language pathology as a distinct specialty in its regulatory impact analysis. A separate category would improve transparency and enable SLPs and their employers—including multidisciplinary organizations—to make informed decisions regarding staffing, budgeting, service delivery, and beneficiary access.

Therefore, ASHA strongly urges CMS to include a separate line for speech-language pathology services in Table D-B5 in the CY 2027 final rule and in future MPFS rulemaking. At a minimum, CMS should publish sufficient specialty- and code-level data to allow stakeholders to calculate independently the aggregate effect of proposed policies on speech-language pathology services.

Conclusion

ASHA appreciates the opportunity to comment on the CY 2027 Medicare Physician Fee Schedule proposed rule. Taken together, these proposals will significantly affect the ability of audiologists and SLPs to provide timely, high-quality services to Medicare beneficiaries.

As CMS develops the final rule, ASHA urges the agency to ensure that payment policies accurately reflect the clinical work and practice expenses required to furnish audiology and speech-language pathology services; provide workable pathways for participation in quality and value-based payment programs; reduce unnecessary administrative burden; and avoid policies that could limit beneficiary access to medically necessary care. ASHA's recommendations include appropriately implementing the new time-based SLP treatment codes, withdrawing the

proposed HCPCS code GSLPP, expanding participation opportunities for audiologists and SLPs in value-based care programs, addressing the effects of the proposed practice expense methodology, and providing a distinct specialty-level impact analysis for speech-language pathology services.

ASHA welcomes continued collaboration with CMS to develop and implement policies that recognize the contributions of audiologists and SLPs, support the financial sustainability of their practices, and preserve access to services that help Medicare beneficiaries communicate effectively, maintain functional independence, and improve their health and quality of life.

If you or your staff have any questions, please contact either of the following ASHA staff members:

Sarah Warren, MA
Director of health care policy for Medicare
American Speech-Language-Hearing Association
swarren@asha.org

Inoka Tennakoon
Director of health care policy, coding and payment
American Speech-Language-Hearing Association
itennakoon@asha.org.

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

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