ASHA
American
Speech-Language-Hearing
Association

January 26, 2026

Administrator Mehmet Oz, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4212–P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Dear Administrator Oz:

On behalf of the American-Speech-Language-Hearing Association (ASHA), I am writing in response to the Medicare Advantage (MA) proposed rule for contract year 2027.

ASHA is the national professional, scientific, and credentialing association for 241,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. ASHA members treat patients who elect Medicare coverage through Advantage plans and have a keen interest in ensuring these plans meet their obligations to clinicians and beneficiaries.

Supplemental Requests for Information

CMS is seeking feedback on areas where requirements can be simplified, consolidated, or eliminated to support this Administration's deregulation priorities. While ASHA supports efforts to reduce administrative burden, network adequacy standards for MA plans must be maintained in order to protect beneficiaries and maintain program integrity. ASHA regularly hears from plan beneficiaries and clinicians about a variety of barriers to obtaining timely access to essential audiology and speech-language pathology services, such as extensive appointment waitlists and protracted provider credentialing processes.

Network adequacy is more than just ensuring a robust pool of clinicians. It also encompasses mechanisms to ensure beneficiaries can obtain services without spending a lot of time or money to travel to appointments. Time and distance standards ensure beneficiaries avoid additional costs for obtaining care such as gas, hotel rooms, and time off work. It is critical to maintain network adequacy time and distance standards to ensure access because MA plans are likely to end access to telehealth audiology and speech language pathology services on January 30, 2026, in alignment with Medicare part B.[1] While MA plans can determine their own telehealth policies, many follow those outlined by Congress for Medicare Part B.

If CMS wants to simplify the network adequacy requirements, ASHA recommends it considers options that do not modify existing regulatory time and distance standards or

provider-to-patient ratios for all specialty types, including audiologists and SLPs, to ensure access for all MA beneficiaries.[2]

Deregulatory efforts should also not be used as justification for eliminating important beneficiary protections. CMS must maintain requirements for supplemental benefit usage notifications and utilization reporting despite its proposals outlined in this rule. CMS recently finalized a rule requiring MA plans to notify beneficiaries of their supplemental benefits and unused benefits because of an increase in supplemental benefit offerings. These offerings increase costs for the beneficiary, but data shows low utilization of these benefits. These requirements are essential to ensure beneficiaries are aware of their full list of benefits and that "MA plans are better stewards of the rebate dollars directed towards these benefits."[3]

Special Enrollment Period for Provider Terminations (§ 422.62(b)(23))

In the proposed rule, CMS suggests that an MA plan enrollee can be eligible for a special election period (SEP) when a provider is terminated from the plan's network. Previously SEP eligibility was restricted to instances when the network changes were deemed "significant." Notice regarding the provider termination and eligibility for an SEP were to be separate, but these notifications would be combined. ASHA supports both of these proposals. Anything that increases transparency and timely access to information to make informed choices about how to manage changes in MA plan provider networks is critically important to maintain access to care for patients. ASHA recommends CMS finalize these proposals.

Rescinding the Requirement for the Notice of Availability (§§ 422.2267(e)(31) and 423.2267(e)(33))

ASHA firmly believes that better health starts with effective communication, which is why we oppose the recission of the Notice of Availability Requirement. Ineffective communication—whether from communication disorders or language barriers—can lead to poorer health, more chronic conditions, avoidance or delays in seeking care, and increased overall health care costs due to preventable adverse events.[4] Therefore, we support retaining the multi-language insert, particularly:

a. The availability in the 15 most common non-English languages in the United States as well as any language that is the primary language of at least 5% of the individuals in a plan; and

b. The requirement to provide alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.

Ensuring access to effective communication improves access by providing everyone a fair opportunity to attain their highest level of health.

Rescind Mid-Year Supplemental Benefits Notice (§§ 422.111(l) and 422.2267(e)(42))

In 2025, CMS finalized—and ASHA supported—a requirement that MA plans provide a mid-year notification to plan enrollees regarding any supplemental benefits not used to date. ASHA believes this is important to maintain access to care for plan enrollees, particularly when they've likely enrolled in a plan in part to receive such benefits and may pay additional premiums for them. Many MA plans offer hearing aid coverage as a supplemental benefit, and audiologists depend on this coverage when seeing patients in need of a hearing aid and related services such as programming.

We were disappointed to see the proposal to rescind this requirement effective in 2027. We urge CMS to not finalize this proposal and maintain this requirement.

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7))

ASHA opposes the recission of this policy as it helps ensure that utilization management is applied equally across all people and doesn't unfairly advantage or disadvantage any group. This policy could be more accurately described as a "fairness audit" used to ensure utilization management is applied across all beneficiaries in the same way.

The suspension of this rule removes a valuable source of information that could help Medicare beneficiaries make more informed choices. Right now, people have very limited access to reliable, plan-specific data during open enrollment, which means most end up choosing an MA plan based solely on premium costs or extra benefits. What many don't realize is that plans can differ significantly in how they handle actual care decisions. By pausing these reporting requirements, CMS is proposing to allow a critical information gap to persist. This would prevent enrollees, their caregivers, researchers, and even the agency itself from seeing how prior authorization policies affect all people—especially those with risk factors and chronic conditions who may face serious consequences—and increased cost to the health care system, if care is delayed or denied.

Request for Information on Future Directions in MA (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

Well-Being

As the U.S. population ages and chronic disease burdens grow, 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.[5] Research suggests that quality of life in older adults depends not only on health status but also on social connections, which may be as equally valued as health status.[6]

Communication disorders can sever patients' links to their communities and natural environment. These conditions vary in type, severity, and co-occurrence with other symptoms that limit mobility, vision, endurance, or cognition.[7] Audiologists and SLPs specialize in the prevention, screening, diagnosis, and treatment (including caregiver training) of communication disorders. Early access to hearing and communication services improves a patient's ability to share and receive essential health information and to maintain the social connections that are vital to their well-being as they age.

ASHA underscores the vital importance of comprehensive functional outcome measures to accurately capture a patient's full range of functional status, including hearing, swallowing, communication, and cognitive function—all of which promote a patient's overall well-being. Failure to capture holistic functional outcomes leaves beneficiaries vulnerable to myriad health risks and avoidable increased costs to Medicare. Accurately measuring these functional domains will capture potential hinderances to social interaction and their downstream effects on well-being. The existing cross-setting discharge function measure used by skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and

long-term care hospitals could serve as a starting point for such measures and be expanded to outpatient settings.

We remain committed to assisting CMS and providers to address all domains of function to include measures complementing the existing cross-setting discharge function measure.

Nutrition

The speech-language pathology scope of practice encompasses assessment, management, and treatment of swallowing and feeding disorders, which can impact a patient's nutritional status. SLPs are the primary providers for swallowing and feeding services, and their role includes identifying signs and symptoms of swallowing problems, evaluating swallow function, and providing treatment to improve swallowing ability. SLPs also often work with patients who are tube fed to help them transition to oral intake. Treatment for feeding and swallowing disorders has been shown to be cost effective with potential cost savings of $54,000 per patient through a reduction in the cost of alternative feeding strategies, such as tube feeding, and prevention of adverse events, such as aspiration pneumonia.[8,9]

Therefore, we encourage CMS to consider ASHA's Functional Communication Measures (FCMs) for swallowing—developed as part of our National Outcomes Measurement System (NOMS)—as the basis for a measure of swallowing skills for oral nutrition. ASHA stands ready to partner with CMS to explore the use of swallowing-specific FCMs and other potential measures to ensure beneficiaries with swallowing and feeding disorders receive adequate nutrition and hydration.

Thank you for your attention to these comments. If you have any questions, please contact Sarah Warren, MA, ASHA's Director for Health Care Policy, Medicare, at swarren@asha.org.

Sincerely,

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

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[2] National Archives and Records Administration. (2026). *Code of Federal Regulations.* https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116
[3] Federal Register. Vol. 89, No. 79. (2024, April 23). *Rules and Regulations.* https://www.federalregister.gov/d/2024-07105/p-36
[4] American Speech-Language-Hearing Association (n.d.). *Communication Access: Better Health Starts with Effective Communication.* https://www.asha.org/communication-access
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