ASHA
American
Speech-Language-Hearing
Association

June 1, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1843-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), we write to offer comments on the skilled nursing facility prospective payment system (SNF PPS) proposed rule for fiscal year 2027.

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 specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. SLPs identify, assess, and treat speech, language, swallowing, and cognitive communication disorders. ASHA members practice in hospitals, skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), outpatient clinics, schools, home health, and private practices. As a result, they have a keen interest in the development of payment and coverage policies that regulate the provision of care to residents of SNFs.

Request for Information: Methodology for Quantifying and Addressing Case Mix Creep Under the Patient Driven Payment Model

Thousands of ASHA members who are SLPs work in SNFs, where they play a critical role in addressing patients' health care needs.[1] Therefore, ASHA has maintained an active role in the development, implementation, and monitoring of the Patient Driven Payment Model (PDPM). ASHA appreciates the collaborative approach CMS has taken in developing PDPM, which is entering its seventh year and addresses significant shortcomings with the previous payment system, the Resource Utilization Group IV (RUG-IV). ASHA strongly supports value-based, patient-centered payment models, which is the intent of PDPM.

However, ASHA is concerned with CMS' request for information (RFI) on addressing what it refers to as "case mix creep." It notes that coding patterns have not aligned with its expectations, which could lead to a negative adjustment factor of nearly 16% for speech-language pathology services. CMS has previously considered targeting payment adjustments to specific elements of the payment system, such as speech-language pathology services, rather than applying a blunt, across-the-board reduction. CMS considered this approach as recently as

2022, but based on feedback received from ASHA and other stakeholders, it ultimately elected not to implement targeted reductions in FY 2023 or subsequent years.

ASHA strongly opposes targeting payment adjustments to specific clinical specialties and urges CMS not to pursue this option in future rulemaking. We maintain that the rationale for a targeted payment adjustment is not supported by the data and will not address CMS' underlying concerns regarding budget neutrality. Such an approach could also undermine access to high quality care and erode the foundational principles of PDPM, which is intended to ensure provision of care based on each patient's clinical characteristics and needs.

The transition to a system designed to meet patient needs based on their clinical characteristics, rather than the volume of services delivered, fundamentally changed the ways SNFs complete the Minimum Data Set (MDS) and submit claims for payment. ASHA believes targeted reductions do not reflect what is occurring in practice, including good-faith efforts by stakeholders to improve the comprehensiveness and accuracy of the diagnosis coding submitted to CMS. Such targeted reductions would essentially penalize SNFs that have worked diligently to align coding practices with the intent of PDPM. Assuming case mix creep is attributable solely to fraud, waste, and abuse—and not also to efforts to align coding practices with the intent of the payment system—weakens our collective efforts to build a value-based payment system.

Instead, ASHA has long maintained that concerns about SNF payments exceeding budget neutrality should focus on ensuring SNFs are meeting their obligations to provide the care they are being paid for. While payments to SNFs have exceeded their costs, tying this differential to case mix creep alone ignores data from both CMS and ASHA indicating that some SNFs have reduced therapy provision to maintain or maximize profits. Applying either across-the-board reductions or targeted adjustments to specific clinical specialties will not achieve CMS' goal of ensuring patient access to medically necessary care. Instead, SNFs may continue offsetting payment reductions by reducing service delivery to maintain profit margins. CMS should continue strengthening oversight of data that may indicate when SNFs are consistently receiving therapy-related payment without furnishing therapy services and should hold those facilities accountable.

CMS Data Does Not Support Parity Adjustments

CMS data has repeatedly shown that payments to SNFs far exceed their costs. This trend is in part explained by significant reductions in the delivery of therapy services in cases where patient demographic data—such as diagnosis—triggers a therapy payment, but little or no therapy is actually furnished.

From the outset, ASHA has emphasized in meetings and written comments that active monitoring of MDS and claims data is critical to ensuring that patients maintain access to medically necessary SNF care. For example, tracking both the number of therapy minutes delivered and the mode of therapy—such as group, concurrent, or individual therapy—is important to ensure that SNFs deliver therapy services in the most clinically appropriate way when receiving a therapy payment.

Following the release of the FY 2020 final rule, ASHA members reported numerous concerning trends in SNFs in response to the transition from RUG-IV to PDPM, including layoffs, reductions in hours, and reduced caseloads. In addition to these anecdotal reports, ASHA conducts a member experience survey every two years. Those survey results show that SLPs in SNFs

continue to face challenges in delivering care to their patients. For example, in response to the 2021 survey, 38% of SLP respondents stated that they had experienced a reduction in hours or a change in employment status from full-time to part-time. In addition, 46% of respondents indicated their SNF caseload had decreased.[2] More recently, 13% of respondents to the 2025 survey indicated their caseload had been reduced by their SNF employer.[3] Workforce and administrative reductions such as these limit access to care for Medicare beneficiaries in SNFs.

CMS data also reflects troubling changes in service delivery patterns, which validates ASHA member reports of reduced therapy service delivery. ASHA maintains that this data will help inform the next steps for optimizing PDPM to ensure patient access to quality care. Stakeholders anticipated a reduction in therapy provision while transitioning from a volume-based to a value-based payment system. However, CMS outlined a reduction of nearly 30% in therapy services during the first three months of PDPM implementation in both the FY 2022 and FY 2023 proposed rules, representing a decrease from an average of 93 minutes per patient per day to 68 minutes per patient per day.

Although some quality metrics, such as hospital readmissions or falls, do not appear to have been affected by these shifts in service delivery, data in the FY 2023 proposed rule indicates more granular metrics of quality may have been negatively impacted. CMS data shows that in the first three months of the PDPM transition, SNF patients experienced higher levels of mood distress, cognitive decline, change in appetite, and weight loss requiring diet modifications. ASHA maintains that some metrics, such as hospital readmissions, are not granular enough to adequately gauge patient experience and outcomes of care, particularly for patients with communication disorders.

Taken together, CMS' internal data and ASHA's membership survey data suggest the changes associated with the payment model reduce access to care, which has contributed to poorer clinical outcomes for SNF patients. ASHA recognizes the importance of budget neutrality to protect the Medicare trust fund. However, when faced with changes in payments, many SNFs respond by cutting care rather than identifying ways to comply with the legal and regulatory requirements of the payment system that would ensure patient access to care and quality outcomes. As a result, ASHA expects that implementation of either a blunt or targeted parity adjustment would lead to further reduction in care delivery and decreased access to and worsened outcomes of care for SNF patients.

ASHA has long supported identifying a mechanism by which CMS could create accountability mechanisms for violations of its regulatory requirements, such as exceeding the 25% limitation on group and concurrent therapy or routinely receiving a therapy payment while delivering little or no therapy. Placing patients in groups reduces the number of clinicians needed to deliver care, creating financial incentives for facilities to increase group utilization.

ASHA fully supports the use of group and concurrent therapy as an important component of service delivery when clinically appropriate—that is, when based on individualized assessment of the patient's needs. However, our survey data continues to show that our members are placed into situations where they must choose between violating their clinical and ethical standards or maintaining employment. For example, nearly 20% of respondents to ASHA's 2021 SLP health care survey reported that they were pressured to provide group treatment despite their clinical judgement that individual therapy was more appropriate based on the patient's clinical presentation.[4]

This trend has continued and appears to have worsened, as 30% of SLPs in SNFs responding to our 2025 survey indicated they were pressured to provide group therapy when they believed individual treatment was in the patient's best interest.[5] Therefore, ASHA reiterates its recommendation for CMS to monitor compliance with the 25% limitation on group and concurrent therapy and use that metric and similar data to implement any payment reductions only for targeted SNFs that are not meeting program requirements.

CMS asserts in the RFI that patient acuity or clinical complexity has not increased. However, ASHA reviewed data from our clinical registry, the National Outcomes Measurement System (NOMS), and ResDAC data. NOMS data indicates that the average length of stay of SNF residents increased from 22.4 days in 2017 to 31 days in 2025. Additionally, the average number of medical diagnoses coded increased from 2.5 in 2017 to 3.8 in 2025. These data points suggest that SNF patients have become more clinically complex and resource-intensive to treat. Before CMS implements any targeted payment adjustment, it should develop a more complete understanding of these types of changes to ensure that any modifications are appropriate, evidenced-based, and aligned with patient care needs.

Targeting Payment Adjustments Undermines PDPM

ASHA strongly opposes targeting the parity adjustment to select service categories, including speech-language pathology services. Through the PDPM technical expert panel (TEP) and associated report, CMS made it clear that enhancing the accuracy of payment for nursing and non-therapy ancillary (NTA) services was an important component of revising the payment system.

Under RUG-IV, therapy utilization often drove care decisions and reimbursement, while nursing and NTA services appeared to be treated as secondary considerations despite their critical importance to patients. In addition, ASHA's TEP representative provided evidence that speech-language pathology services were undervalued in the RUG-IV system. This contributed to CMS' decision to provide a speech-language pathology comorbidity payment and exclude speech-language pathology services from the variable per diem payment applied to physical and occupational therapy services.

By addressing these deficiencies, PDPM enabled more accurate representation of patient needs on the MDS and claims and, for the first time, created a financial structure that supports coding accuracy. As a result, utilization of speech-language pathology services under PDPM more appropriately reflects beneficiary needs. ASHA believes that this level of service delivery is consistent with the care furnished under RUG-IV, but that those services were not previously reported on the MDS since there were no "financial incentives" for SNFs to report them accurately under the previous payment system.

In practice, increased utilization does not equate to fraud, waste, or abuse. Rather, it reflects improved coding and documentation of patient needs. Since the transition to PDPM, ASHA has maintained an extensive member education campaign to ensure SLPs working in SNFs are aware of the payment system requirements and how they can play an effective role in enhancing SNF patient access to care.

ASHA has emphasized to its members the importance of accurate and comprehensive coding on the MDS, claims, and in the medical record. This work has expanded to include partnerships with trade organizations representing SNFs, as well as SNF and contract therapy companies. Through these partnerships, ASHA has encouraged multidisciplinary care teams and

administration to work together to incorporate SLPs into coding and care planning processes to support coding accuracy and ensure that patient needs are appropriately captured.

ASHA members responded by integrating themselves into multidisciplinary care teams to help identify and document the full range of patients who benefit from speech-language pathology services. As a result, targeting speech-language pathology services with a parity adjustment would run counter to the intent of PDPM by discouraging accurate identification of patient needs and provision of medically necessary care. Reducing payment because a SNF appropriately delivered speech-language pathology services would further incentivize arbitrary service reductions driven by financial considerations rather than individualized patient needs.

Thank you for your consideration of our comments. If you have questions or would like additional information, please contact:

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

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[1] American Speech-Language-Hearing Association. (2025). *ASHA 2025 SLP Health Care Survey: Workforce*. www.asha.org
[2] American Speech-Language-Hearing Association. (2021). *SLP Health Care 2021 Survey: Survey Summary Report*. https://www.asha.org/siteassets/surveys/2021-slp-health-care-survey-summary-report.pdf
[3] American Speech-Language-Hearing Association. (2025). *ASHA 2025 SLP Health Care Survey: Workforce*. www.asha.org
[4] American Speech-Language-Hearing Association. (2021). *SLP Health Care 2021 Survey: Survey Summary Report*. https://www.asha.org/siteassets/surveys/2021-slp-health-care-survey-summary-report.pdf
[5] American Speech-Language-Hearing Association. (2025). *ASHA 2025 SLP Health Care Survey: Workforce*. www.asha.org