ASHA
American
Speech-Language-Hearing
Association

January 14, 2026

The Honorable Greg Murphy, MD
U.S. House of Representatives
407 Cannon House Office Building
Washington, DC 20515

The Honorable John Joyce, MD
U.S. House of Representatives
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
U.S. House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

RE: MACRA Modernization Request for Information

Dear Representatives Murphy, Joyce, and Schrier:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write in response to your Request for Information regarding a sustainable Medicare payment system and modernization of the Medicare Access and CHIP Reauthorization Act (MACRA).

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. 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 across the lifespan.

The following responses to your questions provide ASHA's perspective on the effectiveness of MACRA, barriers to provider participation, success of value-based payment models, and recommendations to improve quality payment programs.

Barriers to Increasing Value in the Medicare Program

Inadequacies in the Medicare payment system have resulted in insufficient financial stability needed to support a clinician workforce and maintain beneficiary access to quality care. ASHA shares your goal of modernizing the Medicare payment system to ensure stable and predictable reimbursement for providers and maintain beneficiary access to quality care in a fiscally sustainable manner.

To be successful, reforms to MACRA quality payment policies must occur in tandem with reforms to the Medicare provider payment system that have eroded reimbursement rates over time. These perennial problems relate to longstanding policies such as Medicare sequestration, reductions to the Medicare Physician Fee Schedule (MPFS) conversion factor, and a lack of inflationary adjustment within the MPFS.

These factors result in steep cuts to payments for clinicians' services in an environment where all other sectors of the Medicare program beyond the MPFS receive positive payment updates to account for increasing costs. Several members of the Medicare Payment Advisory

Commission expressed concerns that MACRA leaves clinicians without an update during periods of high inflation. MACRA relies on a financially stable clinician workforce to achieve its goal of expanding two-sided risk models in value-based payment arrangements; broader instability in the Medicare payment system undermines that goal.

ASHA urges Congress to eliminate Medicare Part B reimbursement cuts and provide a permanent inflationary update based on the Medicare Economic Index. Correcting these longstanding payment challenges will help stabilize a clinician workforce that is grappling with an aging population and growing demand for health care services. Fixing these core Medicare provider payment issues is also a prerequisite to a successful shift from pay-for-volume to pay-for-quality.

Ensuring Success of Innovative Payment Models

We believe that delivery and payment reform initiatives must actively engage and include all members of an interprofessional care team, including qualified nonphysician clinicians (e.g., audiologists, SLPs, physical therapists, occupational therapists). Historically, the Center for Medicare and Medicaid Innovation (CMMI) has stated a goal of testing and implementing "Physician Specialty Models." More inclusive terminology—for example, "Comprehensive Payment Models"—would more accurately capture the contributions of the entire clinical care team.

Additionally, despite active participation in several technical expert panels to develop comprehensive alternative payment models and cost/resource use measures, audiologists and SLPs are consistently excluded from final specifications. This exclusion is a missed opportunity to improve the efficacy and efficiency of care through better quality and function and, ultimately lower costs. Despite these barriers, ASHA and its members remain committed to demonstrating the value of the care they provide to patients.

Services performed by audiologists and SLPs should be factored into the development of alternative payment models (APMs), as our members are an integral part of interprofessional care teams treating patients with complex chronic conditions that represent an outsized share of aggregate health care spending. Nonphysician providers also represent a rapidly growing proportion of the clinician workforce. As such, audiologists and SLPs require appropriate considerations to ensure cost and quality are accurately measured and incentivized in future APMs and other pay-for-quality arrangements.

In addition to exclusion from model and measure development, a key barrier to APM participation for audiologists and SLPs is the requirement that the APM use certified electronic health record (EHR) technology. These requirements do not adequately consider participation within system or facility EHRs. Current meaningful use requirements are designed specifically for prescribing providers and often exclude audiologists, SLPs, and other essential health care professionals. Private practice audiologists and SLPs should be exempt from this requirement. Additionally, there are few EHRs available for nonphysician providers, and customization costs can price small practices out of the market.

Audiologists and SLPs play a vital role in secondary and tertiary prevention. The professions play key roles in early detection and intervention to stop or slow the progression of a disorder when it is in its initial stages. They also reduce disability or residual impairment that remains after a disorder has manifested by providing rehabilitation services that maximize functioning.

Inclusion and incentivization of comparatively low-cost interventions provided by audiologists and SLPs can delay or prevent high downstream costs.

As the U.S. population ages and the burden of chronic disease grows, strengthening social connections and psychological well-being—including factors such as 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 status but also on meaningful social connections, which may be valued as highly as health itself.[1] Communication disorders can severely disrupt these essential connections from patients to their community and natural environment. These conditions vary in type, severity, and co-occurrence 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 are vital to their well-being as they age.

Additionally, audiologists and SLPs help ensure that patients and providers are able to clearly and accurately exchange information in the ways 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
- Assist patients and families in maximizing and/or compensating for impaired cognitive functions such as attention, memory, problem-solving, reasoning, and executive function.

Reforming MIPS

Because few APMs include nonphysician clinicians, audiologists and SLPs participate in the Medicare Merit-based Incentive Payment System (MIPS) by default, but on a very limited basis. Many clinicians are excluded from mandatory MIPS participation due to factors such as practice size. Further, the combined risk of a negative adjustment for failing to meet the reporting requirements and the low likelihood of receiving a positive adjustment discourages participation, preventing MIPS from achieving the goal of improving the quality of care for Medicare beneficiaries.

MIPS and APMs currently utilize broad outcome measures (e.g., smoking cessation, BMI) for nonphysician clinicians. These measures often fail to capture the functional independence outcomes—and associated cost-savings—achieved by providers. Appropriate quality metrics are an important check on value-based payment models to ensure quality care is maintained while costs are reduced.

Challenges for nonphysician clinicians extend beyond quality measures, as MIPS includes four performance categories, including EHR interoperability and cost accountability. As noted above, interoperability is a challenge for nonphysicians. With respect to cost, audiologists and SLPs are not responsible for—and are not legally permitted to manage—the full range of medical services a patient may need. However, they could rightly be held accountable for the cost of care associated with the types of interventions they provide as part of an interprofessional team if appropriate cost measures were developed.

ASHA supports moving beyond broad quality measures and redesigning MIPS to better capture the quality and cost associated with nonphysician services to ensure value-based payment programs achieve the goal of improving quality of care while protecting the fiscal health of Medicare.

Outcome measures should include functional measures that are influenced by nonphysician clinicians to avoid creating a disincentive for physicians referring patients for essential services, including those provided by audiologists and SLPs. If value-based payment models measure and reward only physician services—without reflecting the essential role of nonphysician clinicians—they risk underutilizing critical nonphysician services. That can worsen patients' functional outcomes and quality of life and increase overall costs of care.

We also support broader use of patient-reported outcome measures (PROMs), which are becoming more prevalent in value-based care to elevate the patient experience and capture information directly from the patient's perspective on health status, function, symptoms, and quality of life.

Conclusion

ASHA supports incentivizing high-quality, value-based care through reforms to Medicare payment systems. However, significant fluctuations in Medicare reimbursement—including changes to the MPFS and Medicare sequestration—will further erode the financial stability of audiology and speech-language pathology practices, limiting beneficiary access to critical care and undermining efforts to move from volume to value in Medicare. This instability hinders the ability of physician and nonphysician clinicians to support the health and well-being of America's seniors.

We appreciate the opportunity to provide feedback on ways to stabilize the Medicare payment system and improve quality of care through incentive payment programs and look forward to working with you and the committees of jurisdiction on these issues. If you or your staff have any questions, please contact Josh Krantz, ASHA's director of federal affairs, health care, at jkrantz@asha.org.

Sincerely,

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

[1] Lin, F. R., Pike, J. R., Albert, M. S., Arnold, M. L., Burgard, S., Chisolm, T., Couper, D., Deal, J. A., Goman, A. M., Glynn, N. W., Gmelin, T., Gravens-Mueller, L., Hayden, K. M., Huang, A. R., Knopman, D.

S., Mitchell, C. M., Mosley, T. H., Pankow, J. S., Reed, N. S., … ACHIEVE Collaborative Research Group. (2023). *Hearing intervention versus health education control to reduce cognitive decline in older adults with hearing loss in the USA (ACHIEVE): A multicentre, randomised controlled trial.* The Lancet, 402(10404), 786–797. https://doi.org/10.1016/S0140-6736(23)01406-X