

# FORMAL PUBLIC COMMENT

**CMS–1848–P | RIN 0938–AV82**

Fix SLP  
PO Box 444  
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Submitted electronically via Regulations.gov

Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services

Attention: CMS–1848–P

**Re:** CMS–1848–P; RIN 0938–AV82: 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, 91 Fed. Reg. 43842 (July 16, 2026)

Dear Administrator Oz:

Fix SLP respectfully submits these comments on the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule, CMS–1848–P. These comments address the valuation and payment of speech-language pathology (SLP) treatment services, including the proposed pediatric HCPCS code GSLPP and the payment consequences associated with the new time-segmented adult speech-language treatment code structure, as well as the resulting effects on practice expense, workforce capacity, and beneficiary access.

The Speech Pathology Education, Advocacy, and Knowledge (SPEAK) Project is a national data-collection initiative created to quantify the real-world economics and capacity of SLP service delivery. It includes data on the cost of furnishing treatment, clinician and support-staff labor costs, treatment and nonbillable work time, workforce turnover, caseloads, waitlists, and patient complexity. The purpose of the project is to provide policymakers with empirical data about the resources required to furnish SLP services and the potential consequences for patient access when reimbursement does not cover those resources. The quantitative data cited below are preliminary aggregated results from this national dataset and represent more than 1.25 million outpatient services billed under CPT 92507 in 2025, a code that will be replaced as a result of the proposed rule CMS–1848–P. They are presented to inform CMS during the open comment period and are not expected to change materially when the analysis is finalized. A final white paper containing the complete aggregated results and methodology is expected to be furnished directly to CMS and Congress. No patient-level information is included in this comment.

## Executive Summary

The CY 2027 PFS proposals affecting SLP services should be evaluated not only as code-level payment changes, but as changes to a delivery system that preliminary SPEAK Project data indicate is already operating under substantial financial and workforce pressure. Speech-language pathologists evaluate and treat disorders that affect a person's ability to communicate, understand language, use cognition for daily activities, and, in many settings, swallow safely. These services affect whether a child can communicate and participate in school, whether an adult can return home or to work after neurologic injury, and whether an older adult can maintain function and independence. The central concern is therefore not simply provider payment. It is whether Medicare and Medicaid beneficiaries will continue to have timely access to qualified clinicians, and whether a payment policy intended to reduce per-service spending could instead increase total spending by reducing treatment capacity, delaying recovery, increasing the number of visits required, or shifting patients toward more costly levels of care.

- Preliminary SPEAK Project data show an average break-even cost of \$81.86 per treatment session, based on an average intraservice time of 35 minutes and excluding any profit margin. The comparison Medicare payment amount used in the SPEAK analysis is the national average Medicare rate of \$76.15. On that

basis, practices paid at or below that amount are already furnishing the service below the reported average break-even cost.

- Approximately 73% of reported practice operating costs consist of wages, payroll taxes, and employee benefits. Because rent, utilities, standardized clinical materials, and other indirect costs are comparatively fixed, reimbursement reductions place disproportionate pressure on staffing, compensation, and benefits.
- The preliminary 2025 employee turnover ratio is approximately 26%. Reported reasons include movement to better-compensated settings, departure from the profession, childcare and family demands, burnout associated with productivity and unbillable administrative requirements and return to school to pursue other careers.
- Reported average caseloads are 41 patients per SLP and 33 per speech-language pathology assistant (SLPA). Average reported waitlists include 69 Medicaid beneficiaries, 6 Medicare beneficiaries, and 44 patients with other coverage, with an average wait of 4.6 months across ages at the time survey respondents completed the survey (August-September 2026).
- Fifty-two percent of reported caseloads include multiple complexity factors.

Accordingly, Fix SLP requests that CMS use its authority in the final rule to avoid further devaluation of SLP services; ensure that practice-expense inputs reflect the actual cost of maintaining access; evaluate the downstream effect of Medicare payment changes on Medicaid programs that tie rates to Medicare; and establish monitoring and corrective mechanisms if access deteriorates.

## **Detailed Technical Comments**

### **I. Practice Expense Methodology and Valuation of SLP Services**

Relevant rule provisions: Section II.B, Determination of Practice Expense (PE) RVUs; Section II.D, Valuation of Specific Codes, Including Potentially Misvalued Codes; and Section VII, Regulatory Impact Analysis.

CMS explains that PFS payment is based on RVUs for work, practice expense, and malpractice expense, and that practice expense is intended to reflect the resources required to furnish a service, including personnel wages, office expense, administrative labor, supplies, and equipment. The preliminary SPEAK Project results raise a direct question about whether the proposed valuation of SLP treatment services captures those resources accurately.

The SPEAK Project's preliminary aggregated cost accounting places the average break-even cost of furnishing a treatment session at \$81.86, based on an average intraservice time of 35 minutes. This figure does not include a profit margin. The comparison national Medicare payment amount used in the SPEAK analysis is \$76.15. Thus, practices reimbursed at or below that amount are already below the reported average break-even point before any additional reduction in payment.

The cost structure limits the ability of a practice to absorb a reduction without changing care delivery. Preliminary data indicate that approximately 73% of practice operating costs are wages, payroll taxes, and employee benefits. Rent, utilities, standardized assessment and treatment materials, technology, billing infrastructure, compliance costs, and other indirect expenses do not decrease simply because reimbursement decreases. When the largest cost category is labor and labor burden, a payment reduction eventually reaches the people delivering care: fewer clinicians, lower compensation or benefits, reduced hiring, greater use of assistants where permitted, higher productivity expectations, fewer accepted payer contracts, or closure of service lines.

Each of those responses has a beneficiary consequence. A practice that cannot hire another SLP cannot open another treatment slot. A practice that leaves a Medicaid network does not merely reduce its revenue; it removes an access point for beneficiaries. A clinician who leaves outpatient practice for a better-compensated setting takes clinical capacity with them. In communities that already have months-long waitlists, the loss of even a small number of clinicians can translate into delayed evaluations, delayed treatment, longer travel distances, and fewer choices for families.

CMS should therefore evaluate the forthcoming final SPEAK Project cost data as evidence relevant to PE valuation and should avoid assuming that a lower payment amount can be absorbed through generalized practice efficiencies. The relevant question is not whether a practice can temporarily survive a lower rate, but

what operational changes are required to survive it and what those changes do to access, treatment quality, and total program cost.

## **II. Time-Segmented Coding and the Relationship Between Payment Design and Clinical Care**

Relevant rule provisions: Section II.D, Valuation of Specific Codes, Including Potentially Misvalued Codes; Section II.C, Payment for Medicare Telehealth Services, to the extent GSLPP is finalized for telehealth; and Section VII, Regulatory Impact Analysis.

The new adult speech-language treatment code structure uses a 16–30-minute base service with 15-minute add-on increments, while CMS separately proposes pediatric HCPCS code GSLPP with an assumed 60-minute service time. The clinical concern is not that treatment time is irrelevant. Rather, fixed billing increments can become an external constraint on a treatment dose that is otherwise individualized according to diagnosis, complexity, tolerance, goals, intensity, frequency, and response to intervention.

SLP treatment is not a standardized procedure in which every patient receives the same intervention for the same number of minutes. A session may involve language retraining after stroke, cognitive-communication treatment after brain injury, motor-speech treatment, voice treatment, augmentative and alternative communication, caregiver training, or pediatric language and speech intervention. The amount of clinically useful treatment a patient can tolerate can vary substantially even within the same diagnosis. Rehabilitation literature likewise describes dose as multidimensional rather than reducible to elapsed minutes alone, and the RELEASE network meta-analysis found that intensity, frequency, and duration interact in determining treatment response (Harvey et al., 2023; RELEASE Collaborators, 2022). Payment design is also capable of influencing provider behavior and service patterns (Bahari et al., 2022).

CMS should evaluate the payment structure for the incentives it creates, not merely the nominal payment attached to each code. A payment methodology that reduces the price of an individual encounter but increases the number of encounters needed, encourages non-clinically driven treatment duration, or causes providers to reduce participation can be more expensive to the Medicare and Medicaid programs over time while producing worse access for beneficiaries.

## **III. Unbillable Pre- and Post-Service Work and Administrative Burden**

Relevant rule provisions: Section II.B, Determination of PE RVUs; Section II.D, Valuation of Specific Codes; and Section VII, Regulatory Impact Analysis.

Preliminary SPEAK Project results indicate approximately 20 minutes of pre- and post-service work per treatment encounter, including scheduling, documentation, billing-related activities, care coordination, communication with caregivers and other professionals, and development or advancement of person-centered treatment plans. This time is not separately billable, but the employer remains responsible for the associated labor cost.

That distinction is important because an SLP's work does not begin when the patient enters the treatment room and end when the face-to-face portion stops. Clinicians must review relevant medical and educational information, select and prepare treatment materials, document skilled services, update plans, communicate safety or carryover recommendations, coordinate with physicians, nurses, teachers, caregivers, and other rehabilitation professionals, and complete payer requirements. Those activities are part of furnishing safe and effective care even when they do not generate a separate claim.

The administrative implications of a time-segmented structure should therefore be considered as part of valuation. Tracking and documenting discrete time thresholds adds another operational requirement to a service for which practices already report substantial nonbillable work. Published SLP workforce research has identified workload and insufficient time for required documentation as contributors to occupational stress and burnout (Marante et al., 2023).

Fix SLP has identified a growing trend in skilled nursing settings with productivity expectations of approximately 87% or higher in some post-acute environments as a concern. At that level, only a small portion of a paid workday remains for documentation, care coordination, required meetings, transitions between patients, and other nonbillable duties. CMS should not assume that employers can respond to lower reimbursement simply by raising productivity further. There is a practical and legal limit to that strategy: employees must still be paid for compensable work. The Department of Labor recently obtained a \$35.8

million judgment involving 15 western Pennsylvania skilled nursing, rehabilitation, and assisted-living facilities for, among other violations, failing to pay employees for all hours worked (U.S. Department of Labor, 2024). That case does not establish that a particular SLP productivity target is unlawful, but it demonstrates the financial and compliance risk of business models that depend on uncompensated work. This is one of several examples of this type of judgement involving SLPs and SLPAs nationwide.

For beneficiaries, unrealistic productivity pressure can mean less time for care coordination, rushed documentation, reduced clinician availability for family education, and greater burnout and turnover. Those are not peripheral administrative issues; they affect continuity, safety, and the ability of a practice or facility to maintain a stable clinical workforce, with increased financial needs to train and onboard newly hired staff.

CMS should assess whether the direct and indirect PE assumptions adequately account for the administrative labor required to furnish, document, schedule, coordinate, and bill these services and should avoid a valuation that implicitly assumes that already-unbillable work can simply be compressed further.

#### **IV. Workforce Capacity Is an Access-to-Care Issue**

Relevant rule provisions: Section VII, Regulatory Impact Analysis, including effects on providers, suppliers, and beneficiaries.

The preliminary SPEAK Project employee turnover ratio for 2025 is approximately 26%, with reports suggesting continued and increasing pressure in 2026. Reported reasons for departure are primarily structural rather than a lack of interest in clinical practice: compensation and benefit differentials; movement to schools, hospitals, or skilled nursing facilities where compensation may be higher; departure from the profession because continued practice is not financially sustainable; family and childcare economics; burnout associated with productivity, paperwork, and compliance demands; and pursuit of additional education to change careers. 'Not a good fit' was the least frequently reported reason.

Speech-language pathologists cannot be replaced quickly. Entry into the profession requires a master's degree, extensive supervised graduate clinical training, state licensure, and, in 49 states, a post-graduate supervised clinical experience. Academic preparation includes at least 400 hours of supervised clinical practicum, followed in 48 states by a post-graduate supervision period that closely mirrors the 36-week, 1,260-hour experience required for the Certificate of Clinical Competence (CCC), a proprietary credential offered by the American Speech-Language-Hearing Association. Although state licensure establishes an individual as an SLP, the CCC remains erroneously required by many employers and is also incorporated into Medicaid credentialing requirements in approximately seven states, and initial licensing requirements in three states. Although this credential is technically voluntary, much of the time in practice, it is not. This creates an additional financial burden for clinicians, including an annual certification fee of \$221 on top of state licensing costs. New graduates may also earn less during the supervised post-graduate period despite already holding a master's degree, a state license and practicing as SLPs. These costs continue throughout an SLP's career. In addition to recurring state licensure and certification fees, SLPs must complete ongoing continuing education to maintain professional credentials. State requirements vary, but clinicians commonly complete approximately 10–12 hours of continuing education each year to maintain licensure, while maintenance of the CCC carries its own professional-development requirements. These obligations require not only registration fees, but also clinician time and, in some cases, lost revenue or wages associated with time away from patient care. These cumulative education, licensure, supervision, credentialing, and continuing education costs reduce the financial return on entering and remaining in the profession. The Bureau of Labor Statistics identifies a master's degree and state licensure as typical entry requirements and projects SLP employment to grow 17% from 2025 to 2035, with approximately 12,500 openings annually (U.S. Bureau of Labor Statistics, 2026).

The financial return on that training is already a workforce concern. ASHA has reported that master's programs in speech-language pathology may cost approximately \$23,000 to \$75,000 and that more than two-thirds of master's students in communication sciences and disorders report unpaid student debt (American Speech-Language-Hearing Association, 2024). The preliminary SPEAK findings showing departures related to compensation and financial sustainability should therefore be viewed in the context of a profession that requires substantial graduate education and clinical training before independent practice.

Further payment pressure can worsen this mismatch. If practices respond by freezing salaries, reducing benefits, increasing productivity expectations, or eliminating positions, the profession becomes less

competitive relative to other settings and careers requiring comparable education. The immediate effect is a staffing problem; the downstream effect is a pipeline problem. Fewer clinicians remain in community-based and outpatient settings, fewer experienced clinicians are available to supervise trainees, and the time and cost required to replace a departing SLP make lost capacity difficult to restore.

These findings are directionally consistent with national workforce evidence. In the 2025 ASHA SLP Health Care Survey, 44.8% of respondents reported funded, unfilled SLP positions at their facilities. Research in school-based SLPs has likewise documented workload-related stress and burnout, including concerns about time available for documentation (American Speech-Language-Hearing Association, 2025; Marante et al., 2023).

For CMS, the workforce issue is therefore inseparable from beneficiary access. A reimbursement reduction that contributes to even modest additional attrition can mean fewer providers accepting Medicare or Medicaid, longer waits, greater travel distances, interrupted continuity when clinicians leave, and greater reliance on higher-cost institutional or hospital-based settings. CMS should include this workforce-to-access pathway explicitly in its regulatory impact analysis.

## **V. Existing Waitlists Demonstrate Limited Capacity Before Further Payment Pressure**

Relevant rule provisions: Section VII, Regulatory Impact Analysis.

Preliminary SPEAK Project data report average caseloads of 41 patients per SLP and 33 patients per SLPA. Current reported waitlists averages include 69 Medicaid beneficiaries, 6 Medicare beneficiaries, and 44 patients with other coverage, with an average wait time of 4.6 months across all ages.

A waitlist in speech-language pathology is not simply a scheduling inconvenience. It can represent months during which a child cannot effectively communicate needs, participate fully in school, or develop foundational speech and language skills; months during which a working-age adult remains limited after stroke or brain injury; or months during which an older adult and family are managing communication or cognitive limitations without skilled rehabilitation and caregiver training.

For post-stroke aphasia, the timing issue is especially important. Recovery is most rapid early after stroke, with the first months representing an important period of spontaneous and treatment-associated change (El Hachoui et al., 2013), and speech-language therapy is effective for aphasia after stroke (Brady et al., 2016). Payment policy that further constrains provider capacity may therefore delay intervention during a clinically meaningful period. The concern is not that every delay necessarily causes institutionalization; rather, avoidable delay can leave functional needs unresolved for longer and may increase reliance on caregivers, additional health services, or more intensive supports.

The same access concern applies across the lifespan even when the mechanism differs. For pediatric patients, a family that is told to wait four or five months may continue calling other providers, travel farther for care, pay privately if able, or abandon the search. Medicaid beneficiaries have fewer alternatives when private-pay care is not financially possible.

If lower reimbursement causes practices to reduce payer participation, staffing, or treatment capacity, waitlists can lengthen further. That creates a potential false economy for public programs: CMS or a state Medicaid program may spend less per encounter while beneficiaries require more encounters, remain impaired longer, or seek care in more expensive settings. CMS should evaluate total cost and access over the course of an episode of care, not only the unit price of an individual SLP service.

## **VI. Patient Complexity Is Not Fully Reflected in a Uniform Payment Structure**

Relevant rule provisions: Section II.B, Determination of PE RVUs; Section II.D, Valuation of Specific Codes; and Section VII, Regulatory Impact Analysis.

Fifty-two percent of caseloads in the preliminary SPEAK Project data include multiple complexity factors. 'Complexity' in this context means that the communication disorder is not being treated in isolation. A patient may require additional clinician preparation, adaptation of the treatment approach, coordination with other professionals, caregiver training, specialized materials or technology, additional cueing, or closer monitoring in order to provide the same nominal treatment service safely and effectively.

Two examples of increased complexity factors from the SPEAK Project results are bilingual service needs and medical complexity. Bilingual service delivery may require a bilingual clinician, coordination with a qualified interpreter, adaptation of assessment and treatment materials, attention to language difference versus disorder, and additional planning. Practices report difficulty paying a compensation differential needed to recruit bilingual SLPs when reimbursement does not change with the added resource requirement. Medical complexity may require chart review, communication with physicians or nursing staff, monitoring of fatigue or physiologic tolerance, modification of treatment activities, and coordination across multiple diagnoses and medications.

Other clinically common complexity factors illustrate why a uniform code can encompass very different resource demands. These include cognitive impairment that affects learning and carryover; behavioral or sensory regulation needs that reduce the amount of uninterrupted treatment possible; motor, hearing, or vision limitations that require adaptation; use of augmentative and alternative communication devices; caregiver training needs; neurologic conditions with fatigue or fluctuating performance; and social or logistical barriers that require additional coordination. The final SPEAK white paper will enumerate the full set of complexity factors reported by respondents so CMS can evaluate their prevalence directly.

These factors have an economic impact because they consume clinician and staff time that a simple face-to-face minute count does not capture. Two 30-minute encounters can have the same billing duration while requiring very different amounts of preparation, interpretation, caregiver instruction, documentation, technology management, and care coordination. A uniform reduction therefore does not fall uniformly across patients; it places the greatest pressure on providers serving beneficiaries who require the most resources.

The beneficiary risk is predictable. When payment does not recognize complexity, practices have a financial incentive to avoid or limit the most resource-intensive cases, even when those patients have the greatest need. That can disproportionately affect medically complex adults, bilingual families, people who rely on alternative and augmentative communication, and patients who require substantial caregiver involvement. CMS should solicit and evaluate data on the prevalence and resource impact of complexity factors and consider a mechanism to recognize materially higher resource use when supported by the data.

## **VII. Downstream Medicaid Effects Should Be Included in the Impact Analysis**

Relevant rule provisions: Section VII, Regulatory Impact Analysis.

The downstream Medicaid effect is not theoretical. State law and regulation can directly incorporate Medicare payment amounts into Medicaid reimbursement methodology. Kentucky provides a particularly clear SLP-specific example: 907 KAR 8:035 § 2(1) requires Kentucky Medicaid to reimburse an independent speech-language pathologist at 63.75% of the rate for the service on the current Kentucky-specific Medicare Physician Fee Schedule. A parallel regulation, 907 KAR 8:045 § 2(2)(a), applies the same 63.75% Medicare-based rate to SLP services furnished by specified entities. A reduction in the underlying Medicare amount therefore flows directly into the Kentucky fee-for-service Medicaid payment for these services without a separate state determination that the lower amount is adequate.

Ohio illustrates a related mechanism that is especially relevant when existing codes are replaced. Ohio Administrative Code 5160-1-60 provides that Medicaid maximum payment amounts generally may not exceed Medicare's maximum allowed amount and that, when Ohio initially establishes coverage for a new procedure code, the initial Medicaid maximum payment amount is set at 80% of the Medicare allowed amount when a Medicare amount is available. Because CMS-1848-P involves replacement coding for SLP treatment, the federal valuation can therefore influence the starting point for Ohio Medicaid payment for the new codes.

These examples demonstrate why CMS should not model the effect of SLP valuation as confined to Medicare beneficiaries. In states that expressly reference Medicare in their Medicaid payment formulas, federal valuation decisions can propagate into Medicaid, where pediatric beneficiaries comprise a substantial portion of SLP demand. The preliminary SPEAK data already show a substantially larger Medicaid waitlist than Medicare waitlist in the reporting sample.

If the Medicare valuation is below the cost of furnishing care and a state then pays only a percentage of that Medicare amount, the access problem is magnified. Practices may cap Medicaid enrollment, stop accepting new Medicaid patients, reduce staffing, or withdraw from the program because each additional visit increases

the practice's loss. The result can be fewer community providers and greater dependence on hospital systems, schools, or other safety-net settings that may already be unable to absorb additional demand.

CMS should therefore include reasonably foreseeable Medicaid spillover in the regulatory impact analysis and review the final SPEAK Project white paper alongside state-specific payment authorities. The relevant federal impact is not only what Medicare pays after the rule; it is how Medicare's valuation becomes an input into other public payment systems.

### **VIII. CMS Should Evaluate Total Access Effects, Not Only the Nominal Percentage Change in a Single Payment Component**

Relevant rule provisions: Section VII, Regulatory Impact Analysis.

The access and fiscal effect of the CY 2027 policy cannot be understood by examining one conversion-factor percentage or one RVU component in isolation. For SLP services, CMS should evaluate the full chain from payment to practice behavior to workforce capacity to beneficiary outcomes and, ultimately, total program spending.

The preliminary SPEAK data provide the beginning of that chain: reported payment below average break-even cost; a cost base concentrated in labor; approximately 20 minutes of nonbillable work per encounter; substantial turnover; existing waitlists; and high patient complexity. A lower rate does not eliminate those costs. It changes where the costs appear. They may reappear as reduced staffing, longer waits, shorter encounters, additional visits, clinician turnover, recruitment expense, greater caregiver burden, delayed return to work or community participation, or use of more intensive health and supportive services.

For example, if a practice shortens treatment to increase daily volume, the relevant fiscal question is not whether the individual encounter costs CMS less; it is whether the patient then requires more encounters to reach the same functional goal. If a provider stops accepting Medicaid because the rate is unsustainable, the relevant question is what happens to the beneficiary who cannot locate another provider. If an SLP leaves a community practice because compensation no longer supports the educational investment and workload, the relevant question is how quickly that clinical capacity can be replaced. If a stroke survivor waits months for therapy during a period of rapid recovery, the relevant question is whether delayed functional improvement increases downstream dependence on caregivers or government funded services.

These pathways should be evaluated as potential cost-shifting, not dismissed because they occur outside the line item for the individual SLP code. A payment reduction can be budgetarily counterproductive if savings on the unit price are offset by greater utilization, delayed recovery, higher-cost sites of care, or reduced provider participation. The risk is particularly important in Medicaid because state formulas may compound the federal reduction.

CMS should therefore assess the proposed SLP valuations using a total-cost and access framework: cost per completed episode of care, time to treatment, number of visits required, provider participation, workforce turnover, beneficiary travel burden, waitlist growth, and movement to higher-cost settings. The final rule should explain why CMS believes the proposed payment is sufficient to maintain the workforce and treatment capacity necessary to avoid these downstream costs.

### **Alternative Recommendations**

Based on the preliminary SPEAK Project findings and the concerns described above, Fix SLP respectfully recommends that CMS:

1. Revalue SLP treatment services so payment does not further widen the documented gap between reimbursement and the average break-even cost of furnishing care. At minimum, CMS should avoid additional devaluation until it has reviewed the final SPEAK Project cost data and methodology.
2. For pediatric services, if CMS moves forward with GSLPP, value the service in a manner that preserves the resources necessary to furnish the clinical service, including indirect practice expense and the substantial non-face-to-face work required for pediatric care. If CMS cannot establish a valuation that supports access, it should not finalize a payment structure that further destabilizes pediatric service delivery.
3. For adult services, evaluate the behavioral and administrative effects of the 16-30-minute base/15-minute add-on structure.

4. Incorporate the approximately 20 minutes of reported pre- and post-service work per encounter into the assessment of resources required to furnish SLP treatment, and do not assume that higher productivity can absorb this work without workforce, compliance, or quality consequences.
5. Include a specific SLP workforce and access analysis in the final rule that considers turnover, funded vacancies, graduate-level training requirements, workforce replacement time, caseloads, waitlist duration, and the effect of reimbursement on recruitment and retention.
6. Account for downstream Medicaid effects where state payment methodology incorporates Medicare rates. At minimum, CMS should specifically consider the provided examples of Kentucky's 63.75%-of-Medicare SLP reimbursement methodology and Ohio's Medicare-linked methodology for establishing payment for new procedure codes.
7. Evaluate resource-intensive complexity factors and consider an appropriate mechanism to recognize materially higher resource use. The final SPEAK white paper should be reviewed for the complete set of complexity factors reported by participating practices.
8. Establish post-implementation monitoring for SLP access and total cost, including waitlist duration, time to treatment, provider participation, practice closures or service-line reductions, workforce vacancies, treatment visits per episode, and movement to higher-cost settings, with a defined process to revisit valuation if access deteriorates or total costs increase.

## **Conclusion**

The preliminary SPEAK Project results indicate that SLP practices are not approaching CY 2027 from a position of excess capacity or substantial financial margin. The reported average break-even cost exceeds the Medicare comparison payment used in the analysis; labor accounts for most operating expense; substantial pre- and post-service work remains unbillable; turnover is significant; and patients are already waiting months for care. Because SLPs require graduate-level education and extensive supervised clinical training, lost workforce capacity cannot be replaced quickly.

This data warrants more than a narrow assessment of the amount saved on an individual claim. A lower unit payment can increase total public spending if it reduces provider participation, lengthens waitlists, causes patients to require more visits, delays functional recovery, or shifts care toward more intensive and expensive settings. Fix SLP respectfully requests that CMS evaluate the final SPEAK Project white paper when it is furnished, incorporate Medicare and downstream Medicaid access effects into the final regulatory impact analysis, and establish CY 2027 payment for SLP services at a level that reflects the actual resources required to maintain a trained workforce and timely beneficiary access.

Thank you for the opportunity to comment.

Respectfully submitted,

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