



June 1, 2026

Dr. Mehmet Oz, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1843-P  
PO Box 8016  
Baltimore, MD 21244-8016

*Submitted electronically at <http://www.regulations.gov>*

**RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027 (CMS-1843-P)**

Dear Administrator Oz:

The National Association of Rehabilitation Providers and Agencies (NARA) represents more than 100,000 practitioners of physical therapy, occupational therapy, and speech-language pathology through our member organizations. These providers deliver therapy services to Medicare and Medicaid beneficiaries across the United States in a wide range of care settings, including skilled nursing facilities, assisted living facilities, outpatient clinics, hospital inpatient and outpatient departments, beneficiaries' homes, and retirement communities.

As a member-driven organization, NARA is dedicated to ensuring access to care for beneficiaries and advancing the growth and business success of rehabilitation providers through education, support, and advocacy. Our diverse membership gives us a unique and comprehensive perspective on payment and quality programs affecting skilled nursing facilities (SNF). Below are our comments on the proposed rule:

**Proposed Updates to the SNF Payment Rates**

NARA appreciates the proposed payment increase but we urge CMS to ensure SNF reimbursement keeps pace with the actual and rising cost of furnishing high-quality post-acute and skilled nursing care. CMS's own proposed rule recognizes that the SNF market basket is intended to reflect changes in the prices of the goods and services used to deliver covered SNF care, including routine, ancillary, and capital-related costs. CMS also estimates that the FY 2027 SNF labor-related share is forecasted to be 72.0%, underscoring that SNF care is highly labor-intensive and especially vulnerable to sustained increases in wages, benefits, contracted labor, and workforce recruitment and retention costs. A net 2.4% update, particularly when reduced further for some providers through Value-Based Purchasing (VBP) adjustments and when paired with the possibility of future Patient-Driven Payment Model (PDPM) recalibration, may not be sufficient to preserve financial viability for SNFs already operating under significant workforce,

inflationary, and access pressures. CMS should use the most current market basket, productivity, labor, and cost data available in the final rule and avoid future payment reductions that are not carefully calibrated to actual patient acuity, resource use, and the real-world cost of maintaining access to medically necessary SNF care.

### **All Payer MDS Submission**

We appreciate CMS's stated goal of obtaining a more complete and accurate representation of quality for residents receiving skilled care in SNFs, regardless of payer. However, we urge CMS to proceed cautiously with the proposal to require MDS submission for all residents receiving covered skilled care, regardless of payer, beginning with residents admitted on October 1, 2029, for purposes of the FY 2031 SNF QRP. CMS states that it is not proposing changes to public reporting policies for non-Medicare FFS residents at this time, but the proposal would still permit the SNF QRP to make publicly available information regarding the quality of services furnished to the SNF population as a whole. Providers need clear direction now regarding how this data will ultimately be used, whether all-payer data will be combined with Medicare FFS data, and how CMS will prevent inaccurate comparisons or unintended reputational harm.

As CMS begins to evaluate all-payer MDS data, we urge the agency to carefully consider the unique factors associated with Medicare Advantage residents and the extent to which payer decisions may influence reported outcomes. For Medicare Advantage residents, SNFs often do not control the timing or clinical appropriateness of discharge decisions. MA plans may authorize shorter stays, deny continued coverage, or require discharge even when the provider believes additional skilled care is clinically appropriate and would support better patient outcomes. As CMS analyzes these data, it will be important to distinguish provider-driven care decisions from payer-driven utilization management decisions, including interrupted coverage, denied days, shortened lengths of stay, premature discharge, and other MA plan actions. CMS should account for these factors before using all-payer data for quality measurement, public reporting, preferred network evaluation, or future payment-related programs to ensure SNFs are evaluated fairly and that the data accurately reflect provider performance rather than payer-imposed limitations on care.

We also urge CMS to address the compliance risk created by the proposal's reliance on whether services are "covered skilled care" for non-Medicare FFS residents. The proposed framework appears to distinguish between residents admitted or readmitted for covered skilled services, long-term residents who become skilled in place, residents who leave and return within an interruption window, and residents whose services are not covered. While this framework may be intended to align with Medicare Benefit Policy Manual concepts, it creates operational uncertainty when applied to all payers. Providers will need clear, payer-neutral definitions and examples to determine when an all-payer MDS admission or discharge assessment is required, how to document the start and end dates of a covered skilled stay, how to handle payer denials or retroactive authorization changes, and how to reconcile conflicting payer rules. Without clear guidance, facilities face significant compliance exposure for submission errors, missed assessments, or inconsistent interpretation of coverage status across Medicare Advantage, Medicaid managed care, commercial plans, and other payer arrangements.

CMS should also revisit its burden estimates. The proposed rule acknowledges that all-payer MDS submission would increase burden, including an estimated additional 1,133,649 MDS assessments annually and more than one million additional burden hours beginning with the FY 2031 SNF QRP. However, the actual burden to providers is likely greater than CMS has calculated. It includes the full operational process necessary to ensure that MDS data is accurate, complete, timely, and defensible under QRP compliance standards.

Finally, we caution CMS against comparing SNF all-payer MDS data to data from other post-acute settings without carefully accounting for differences in patient populations, payer behavior, length of stay, discharge control, regulatory requirements, and facility responsibilities. SNFs are unique in that MDS data serves multiple purposes beyond quality reporting, including care planning, Medicare payment, OBRA requirements, state Medicaid programs, and other state-specific payment and quality functions. Because of these unique uses, expanding MDS submission is not merely a technical alignment with other PAC quality reporting programs. It is a substantial operational and compliance change for SNFs. CMS should delay finalizing or implementing this proposal until:

1. **Operational definitions are clearly documented and explained.** CMS needs to provide detailed guidance on when an all-payer MDS is required, especially for residents who become skilled in place, leave and return within an interruption window, have payer denials, experience retroactive coverage changes, or receive services under Medicare Advantage, Medicaid managed care, commercial insurance, or other payer arrangements.
2. **Providers are given ample time to understand how “covered skilled care” will be determined across payers.** The concept of covered skilled care is not applied uniformly by all payers. MA plans, Medicaid managed care plans, and commercial payers may use different authorization, denial, and coverage rules. Without payer-neutral definitions, SNFs face significant risk of inconsistent reporting and compliance exposure.
3. **The burden can be more accurately estimated.** All-payer MDS collection is not simply a data-entry exercise. It requires clinical assessment, interdisciplinary coordination, coding, payer verification, software workflows, quality assurance, transmission, correction, and staff training. CMS should conduct additional burden analysis before implementation.
4. **Software vendors and EHR systems are provided development time.** MDS software, billing systems, quality dashboards, payer tracking tools, and electronic health record workflows will need updates to capture all-payer skilled stays accurately. Vendors and providers need adequate testing time before the requirement becomes mandatory.
5. **Medicare Advantage utilization management potential distorted outcomes are differentiated.** SNFs often do not control MA plan decisions regarding authorization, denied days, shortened stays, or discharge timing. CMS should first determine how it will distinguish provider performance from payer-driven care limitations.
6. **System processes allow for payer attribution .** If all-payer data are aggregated without payer-specific attribution, facilities may appear to perform differently because of payer policies rather than care quality. CMS should develop payer stratification and attribution standards before implementation.

We recommend CMS pilot or test the process first. A phased pilot would allow CMS to identify operational problems, payer-specific inconsistencies, data quality issues, and unintended consequences before imposing nationwide compliance obligations.

#### **Update to SNF VBP Snapshot Date Definition for the Discharge Function and Falls Measure**

NARA supports CMS's proposal to update the SNF VBP "snapshot date" definition for the Discharge Function Score for SNFs measure and the Falls with Major Injury (Long-Stay) measure beginning with data collected in FY 2027. CMS proposes to align the snapshot date for these MDS-based VBP measures with the revised SNF QRP MDS submission deadline, so that the snapshot date would be the 15th day of the second month after the last day of the applicable baseline or performance period. We agree that this alignment is appropriate and will help ensure greater consistency across SNF quality reporting and value-based purchasing programs. CMS has stated that the related SNF QRP MDS submission timeline revision is intended to reduce the lag in public reporting by up to three months, resulting in more timely quality information for consumers and families.

Timely and accurate MDS data are essential for meaningful value-based purchasing, particularly for measures tied to functional outcomes and falls with major injury. NARA supports CMS's effort to make VBP data more current and better aligned with the timeframe in which providers are delivering care and implementing quality improvement strategies. More timely data can improve the usefulness of the review and correction process, support more accurate performance assessment, and help ensure that SNFs are evaluated on information that better reflects current operations and patient outcomes. We encourage CMS to finalize this proposal while also providing clear operational guidance, adequate education, and technical support so that SNFs can meet the accelerated timeline while maintaining data accuracy and completeness.

#### **Request for Information: Case-Mix Creep Under PDPM**

NARA appreciates the opportunity to respond to CMS's Request for Information on a potential methodology for quantifying and addressing case-mix creep under the Patient Driven Payment Model (PDPM). At this time, NARA does not believe any PDPM case-mix creep adjustment should be included in future rulemaking without first releasing substantially more detail, underlying data, provider-level impact files, and sufficient opportunity for stakeholder review. It is difficult for providers and stakeholders to meaningfully respond to the methodology described in the proposed rule because CMS has not provided enough information or data files to allow the field to verify, replicate, or fully investigate the assumptions, regression framework, and adjustment factors. Given the magnitude of the potential reductions identified in the RFI, including the possibility of a system-wide adjustment that CMS describes as a 4.3 percent reduction in CMIs or base rates, or a 3.6 percent reduction in total payment across the PDPM system, CMS should not proceed without a transparent, reproducible analysis and a clear explanation of how the methodology distinguishes true coding behavior from legitimate changes in patient acuity, payer mix, site-of-care patterns, and post-acute care access.

NARA is also concerned that CMS's analytic period compares pre-PDPM data to post-PDPM data, which is inherently flawed for purposes of identifying alleged case-mix creep. PDPM was implemented beginning October 1, 2019, and represented a fundamental change in the SNF payment classification system. Comparing periods before and after the transition to PDPM risks conflating actual changes in resident classification, clinical documentation, coding education, hospital referral patterns, post-acute care utilization, and pandemic-era disruption with inappropriate coding behavior. CMS's own methodology memo indicates that the analysis uses FY 2017 through FY 2024 and assigns estimated PDPM case-mix groups to pre-PDPM years for consistency. While that approach may be useful for modeling, it should not be treated as sufficiently reliable to justify future payment reductions unless CMS can demonstrate that the methodology accurately separates true patient acuity and utilization changes from nominal coding changes across two materially different payment systems. NARA further questions why an additional case-mix creep adjustment is being considered when CMS has already addressed the behavioral shift associated with PDPM implementation through the parity adjustment. In the FY 2023 SNF PPS final rule, CMS finalized a 4.6 percent parity adjustment recalibration, phased in over two years, after concluding that actual payments under PDPM exceeded expected levels. That parity adjustment was specifically intended to address budget neutrality and implementation-related behavioral or coding changes following the transition from RUG-IV to PDPM. CMS should not layer another payment reduction on top of that recalibration unless it can clearly demonstrate that the proposed adjustment captures new, separate, and independently validated changes that were not already addressed by the PDPM parity adjustment. Otherwise, the policy risks double-counting the same behavior shift and imposing duplicative reductions on SNFs.

This is not the appropriate time to implement a new PDPM case-mix creep adjustment. The SNF sector is entering a period of significant payer and policy disruption that will materially affect case mix over the next several years. Medicare Advantage enrollment continues to grow, and MA plans increasingly influence post-acute care access, length of stay, discharge timing, documentation, and care transitions. At the same time, federal Medicaid financing changes and reductions are expected to place additional pressure on nursing facilities, state Medicaid programs, staffing, and long-term care access. These changes will affect the composition and acuity of residents remaining in SNFs, the availability of covered skilled care, and the financial viability of facilities. Implementing a new PDPM adjustment during this period would risk reducing Medicare SNF payments based on retrospective assumptions that do not reflect the rapidly changing payer environment and the real-world acuity of patients served.

For these reasons, NARA urges CMS to release complete data files, detailed methodology, provider-level impact analyses, and alternative modeling for stakeholder review before the agency proposes anything. CMS should also explicitly account for Medicare Advantage growth, Medicaid financing reductions, changes in post-acute referral patterns, shortened lengths of stay, payer-driven utilization management, and the prior PDPM parity adjustment before considering any future recalibration. Any future methodology must be transparent, empirically sound, replicable, and narrowly tailored to avoid duplicative reductions or penalties for legitimate changes in patient acuity and care delivery.

### **Skilled Nursing Facility Quality Reporting Program: RFI: Advanced Care Planning**

NARA appreciates CMS's focus on person-centered care and recognizes the importance of advance care planning in supporting residents' goals, values, and preferences during skilled nursing and post-acute care episodes. CMS describes advance care planning as a continuous process that helps individuals understand and communicate their preferences for future medical decisions and notes that resident needs and goals may change during post-acute recovery. NARA agrees that these conversations are important and clinically meaningful. However, NARA urges CMS to proceed cautiously before developing or adopting a new SNF QRP measure on advance care planning because advance directive rights and related facility obligations **already exist in the nursing facility Conditions of Participation at § 489.102**. Federal regulations already provide that residents have the right to request, refuse, and/or discontinue treatment and to formulate an advance directive. Facilities are also required to inform and provide written information to adult residents regarding the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive, including a written description of facility policies and applicable state law.

Since these requirements already exist, CMS should clearly explain what gap a new quality measure is intended to fill and how the measure would improve resident outcomes beyond existing regulatory compliance obligations. NARA is concerned that a poorly designed measure could become a documentation exercise rather than a meaningful reflection of person-centered care. CMS should clarify whether the measure would be a simple "checkbox" indicating that advance care planning was discussed or documented, or whether it would evaluate whether the resident's goals, preferences, surrogate decision-maker, advance directive status, and care transition needs were meaningfully assessed and acted upon. A checkbox-only measure risks creating administrative burden without demonstrating whether the resident's wishes were understood, honored, communicated across settings, or incorporated into the plan of care.

If CMS intends the measure to support communication across providers, interoperability must be central to the measure design. Advance care planning information is only useful if it can follow the resident across hospitals, SNFs, home health, hospice, outpatient providers, and other care settings in a timely and usable format. CMS should not finalize any measure that requires SNFs to collect or report additional information unless the data can be exchanged electronically and reliably with other providers and incorporated into existing workflows. CMS itself notes that advance care planning supports goal-concordant care throughout care transitions, and the proposed rule elsewhere emphasizes the value of longitudinal information exchange between SNFs and other providers.

NARA therefore recommends CMS first define the specific quality gap, test the measure in the SNF setting, assess burden, and ensure interoperability before proposing an advance care planning measure for the SNF QRP. Any future measure should avoid duplicating existing Conditions of Participation, should not penalize providers when residents decline to engage in advance care planning, and should recognize that advance care planning is an ongoing process

influenced by resident capacity, family involvement, state law, prognosis, transitions of care, and clinical change. CMS should focus on whether information is available, accurate, updated when appropriate, and transferable across settings not merely whether a box was checked in the MDS or medical record.

### **SNF Wage Index**

NARA appreciates CMS's request for feedback on the unique considerations applicable to SNFs that should inform whether CMS could consider alternative data sources for the SNF wage index in future rulemaking. For FY 2027, CMS proposes to continue using the concurrent, pre-floor, pre-reclassified inpatient hospital wage index as the basis for the SNF wage index, while maintaining the permanent 5 percent cap on wage index decreases. CMS also proposes a FY 2027 labor-related share of 72.0 percent and a wage-index budget neutrality factor of 0.9987. NARA recognizes that this proposal does not create a new wage-index methodology that uniquely changes therapy payment; however, because the labor-related share is such a significant component of SNF PPS payment, geographic wage index variation continues to have a meaningful impact on the resources available to support therapy staffing, nursing, clinical operations, and other labor-intensive services.

NARA urges CMS to carefully consider whether the current hospital-based wage index adequately reflects the labor realities of SNFs. SNFs compete for many of the same licensed and clinical professionals as hospitals, home health agencies, outpatient providers, schools, staffing agencies, and Medicare Advantage-contracted networks, but they often do so with different payer mixes, regulatory requirements, staffing expectations, and reimbursement constraints. Therapy providers in SNFs are particularly affected by local labor market pressures, including shortages of physical therapists, occupational therapists, speech-language pathologists, assistants, nursing staff, and other clinical personnel. These pressures are not always captured accurately through a hospital wage index methodology that was not designed around the SNF workforce or SNF cost structure.

If CMS considers alternative data sources in the future, NARA recommends that the agency evaluate whether those sources more accurately reflect SNF-specific labor costs, rural and urban workforce shortages, contracted labor reliance, therapy staffing costs, wage compression, recruitment and retention expenses, and the increasing competition for clinicians across care settings. CMS should also ensure that any future alternative methodology is transparent, budget-neutral impacts are clearly modeled, and provider-level impact files are released with sufficient time for review. Any new wage-index approach must avoid destabilizing providers in already fragile labor markets and should be tested carefully before implementation.

NARA also recommends that CMS evaluate therapy-specific workforce considerations as part of any future wage index analysis. Therapy services are central to SNF care, functional improvement, discharge planning, fall prevention, and safe transitions back to the community. If local wage data do not accurately reflect the cost of recruiting and retaining qualified therapy professionals, SNFs may face additional challenges maintaining access to medically necessary rehabilitation services. NARA therefore supports CMS's continued evaluation of wage index data

sources but urges CMS to ensure that any future changes are grounded in SNF-specific labor realities and do not inadvertently reduce access to therapy and other skilled services.

### **Credentialing Barriers with Medicare Advantage Organizations**

NARA continues to hear significant concerns from members regarding the impact of Medicare Advantage credentialing and contracting processes on patient access, provider administrative burden, and financial sustainability. Commercial payers offering MA plans often maintain restricted provider networks and require credentialing and contracting processes that can take 90 to 180 days to complete. During this time, beneficiaries may face substantial delays in accessing timely therapy and skilled care, particularly those enrolled in HMO plans, individuals with limited transportation options, and residents of assisted living or independent living communities where an on-site provider is available but not yet credentialed with the beneficiary's MA plan.

These delays create a direct access-to-care issue. When a physician refers a beneficiary for therapy or skilled services, the patient's ability to begin care should not depend on a several months-long payer contracting process. This is especially problematic for medically complex, frail, or mobility-limited beneficiaries who may experience functional decline, increased fall risk, delayed recovery, or avoidable transitions to higher-cost settings when care is postponed. The lack of retroactive contract effective dates further compounds the problem. Unlike traditional Medicare, where eligible providers may receive a retroactive enrollment effective date within established CMS parameters, many MA plans delay contract activation without retroactivity. As a result, beneficiaries may be unable to receive covered care from an otherwise qualified Medicare provider for months after referral, even when that provider is available, appropriately licensed, and prepared to furnish services.

The administrative burden associated with MA credentialing and contracting is also substantial. Providers must navigate inconsistent payer-specific applications, duplicative documentation requests, long response times, unclear status updates, and delayed contract loading. These processes divert staff time and resources away from patient care, increase overhead, and create operational uncertainty. For small and community-based therapy providers, the burden is especially acute because they often lack the administrative infrastructure to absorb repeated delays across multiple MA plans.

These access and administrative challenges are compounded by financial pressure. Providers are frequently required to accept lower reimbursement rates while also absorbing the cost of prolonged credentialing timelines, delayed effective dates, repeated follow-up, payer-specific prior authorization requirements, and claim denials when enrollment or contract loading is incomplete. This combination of lower payment and higher administrative burden makes participation in MA networks increasingly unsustainable. Over time, this can reduce provider participation, narrow already-limited networks, and further restrict beneficiary access to medically necessary therapy and skilled care.

NARA urges CMS to strengthen oversight of MA credentialing, contracting, and network management practices to ensure that beneficiaries have meaningful and timely access to care. Specifically, CMS should standardize and streamline MA credentialing and contracting processes; establish clear timeliness standards for payer review, approval, and contract loading; require retroactive effective dates for qualified Medicare-enrolled providers when appropriate; increase transparency regarding network adequacy and provider onboarding timelines; and monitor whether administrative delays are interfering with beneficiary access to covered services. As MA enrollment continues to grow, CMS must ensure that plan administrative processes keep pace with beneficiary needs and do not create avoidable barriers to care, excessive provider burden, or unsustainable financial conditions that discourage provider participation in MA networks.

### **Conclusion**

Our members continue to face significant challenges in sustaining operations and delivering high-quality care in an environment marked by ongoing reimbursement reductions, rising costs, and increased regulatory penalties. Providers are working diligently to safeguard the health and well-being of both patients and staff; however, they consistently report that excessive administrative requirements divert critical time, resources, and clinical expertise away from direct patient care. Many of these regulatory tasks are not well aligned with staff roles or skillsets, creating inefficiencies, increasing burnout, and ultimately threatening patient access to essential rehabilitation and skilled care services.

Thank you again for the opportunity to provide input. Should you have any questions regarding our comments, please contact Christie Covington, NARA Executive Director, at [christie.covington@naranet.org](mailto:christie.covington@naranet.org).

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Christopher Carlin". The signature is fluid and cursive, with the first name "Christopher" being more prominent than the last name "Carlin".

Christopher Carlin, MBA, OTR/L  
President of the Board

National Association of Rehabilitation Providers and Agencies