

June 1, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027; 91 Fed. Reg. 17,676 (April 7, 2026).

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, including approximately 500 skilled-nursing facilities (SNFs), our clinician partners — more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2027 SNF prospective payment system (PPS) proposed rule.

SNFs play a critical role in the continuum of care. Ensuring access to this frequently used discharge destination is crucial for patients continuing their recovery following a hospitalization. Due to the important role of SNFs, we are concerned that the proposed FY 2027 payment update remains inadequate in light of sustained cost increases. **As such, the AHA urges CMS to strengthen the FY 2027 SNF payment update by revisiting the market basket forecast and working with Congress to reduce the magnitude of the productivity adjustment. Further, we urge CMS not to pursue additional case-mix creep adjustments under the current request for information (RFI) framework, which risks duplicating prior parity adjustments and penalizing appropriate adaptation to the Patient-driven Payment Model (PDPM).**

Our detailed comments follow.



MARKET BASKET UPDATE

The AHA remains concerned that CMS' proposed annual market basket update of 3.2% is not keeping pace with real-world cost growth. In recent years, CMS' market basket forecasts have consistently come in below broader inflation, let alone medical inflation, which has exceeded growth in the overall economy. Layered on top of that, the productivity adjustment, proposed to be 0.8 percentage points for FY 2027, further erodes the update, leaving Medicare payments increasingly out of sync with the cost of care. We urge CMS to revisit both its market basket forecasts and the magnitude of the productivity adjustment, and to consider their combined effect on provider reimbursements.

Rising Costs of Care Continue to Strain Healthcare Providers

Providers, such as hospitals and SNFs, continue to face sustained inflationary pressures. As detailed in our [comments](#) on the FY 2026 SNF proposed rule, inflation has continuously pushed up labor, drug, supply and other core operating costs. A recent AHA report found that total hospital expenses increased by 7.5% in 2025 alone.¹ Much of this increase reflects labor costs, which CMS notes account for nearly three-quarters of the SNF market basket. Indeed, an AHA analysis found that workforce costs rose by 5.6% in 2025.² Further, advertised salaries for registered nurses have averaged 5.5% growth over the last two years — more than double the rate of inflation.³ While some of these figures are specific to hospitals, SNFs utilize a very similar market basket, competing for the same skilled clinicians and supplies. Moreover, we have [expressed concern](#) that recent actions, such as changes to federal student loan limits that exclude nurses and other clinicians from enhanced borrowing limits, will exacerbate workforce shortages, which contribute to higher costs for labor.

Cost pressures, however, extend well beyond labor. Like other providers, SNFs are increasingly caring for sicker and more complex patients, requiring additional and more costly drugs and supplies, and these costs also continue to climb. An AHA analysis showed that in 2025, supply costs rose 9.9%, while drug costs rose a staggering 13.6%.⁴ In addition, a Health and Human Services (HHS) report found that list prices for nearly 2,000 drugs increased by an average of 15.2% from 2017 through 2023 — outpacing general inflation.⁵ These cost challenges strain SNFs, which must be prepared to provide treatment for a wide range of conditions and comorbidities.

¹ AHA. (March 2026). The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (<https://www.aha.org/costsofcaring>).

² Id.

³ Id.

⁴ Id.

⁵ ASPE. (October 2023). Changes in the List Prices of Prescription Drugs, 2017-2023. (<https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs>).

Providers also are absorbing escalating administrative costs that are not reflected in payment updates. In particular, most Medicare Advantage (MA) plans require prior authorization for post-acute admissions, and SNFs must devote substantial time and resources to navigating these processes. The HHS Office of Inspector General found that many post-acute care prior authorization requests were denied inappropriately, requiring providers to expend significant resources appealing erroneous denials.⁶ Since plans do not reimburse these administrative expenses, providers must absorb them while caring for a growing share of MA patients.

Viewed collectively, these cost increases for staffing, drugs, and other essential supplies and services are placing significant strain across the healthcare continuum. They also are forcing providers to redirect resources that otherwise could be used to support patient care, adopt new technologies and make other efficiency-enhancing investments. That reality makes CMS' market basket updates, which fall well below the levels of growth observed in labor, drugs, supplies and other costs, insufficient. As discussed further below, these same pressures also amplify the negative impact of the productivity adjustment on providers' ability to fund the very investments that can drive operational efficiencies.

The Productivity Adjustment Exacerbates Insufficient Market Basket Updates

Under the Affordable Care Act, the SNF PPS payment update is reduced each year by a productivity factor equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP). The private nonfarm business TFP is intended to reflect gains from new technologies, economies of scale, business acumen, managerial skill and changes in production. As such, it effectively assumes that the healthcare field can achieve productivity gains comparable to those realized by private nonfarm businesses. However, as discussed in more detail below and in a report shared in last year's comments, the healthcare field cannot mirror these gains.⁷ As a result, it is not an appropriate or reliable proxy for healthcare productivity. **Therefore, we ask CMS to work with Congress to reduce the magnitude of the productivity adjustment.**

A core problem is that the productivity construct embedded in the private nonfarm business TFP is a poor fit for measuring healthcare productivity. TFP outputs are measured based on the total quantity and prices of goods and services produced in private nonfarm businesses. In industries that sell tangible products, outputs can often be measured in relatively straightforward and standardized ways. Healthcare outputs, however, do not operate in the same manner. For example, healthcare "quantity," such

⁶ HHS OIG. (April 2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (<https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/>).

⁷ <https://www.aha.org/system/files/media/file/2025/06/aha-comments-on-cms-skilled-nursing-facility-fy-2026-proposed-payment-rule-letter-6-10-2025.pdf>.

as volume of visits or procedures, is not necessarily an appropriate proxy for output; it may instead reflect the underlying disease burden in a community. More provider volume — i.e., more quantity — does not equate to higher productivity in the way it can for private nonfarm businesses.

Further, providers often cannot adjust prices per unit of service in response to changes in demand or quality in the way private nonfarm businesses can. Much of SNFs' reimbursement is paid through fixed payment systems, such as the SNF PPS, which limits providers' ability to alter prices. Similar constraints apply in the commercial market: providers do not unilaterally set their rates, and prices for commercially insured patients are established through negotiations that frequently lock in rates for multiple years. Accordingly, applying a TFP output framework based on quantity and prices — as experienced in the private sector — to healthcare providers is problematic because that output function does not translate to the healthcare field.

In addition, SNFs also differ from many private nonfarm industries because healthcare services are inherently labor-intensive. As discussed further in the report referenced above, economic literature has long recognized that sustained productivity gains are difficult to achieve in labor-intensive service industries because labor cannot be scaled or automated in the same way as in other sectors. In this respect, healthcare providers are more comparable to fields such as education and social assistance, which tend to experience lower total factor productivity rates. For example, Bureau of Labor Statistics data show rates ranging from -0.4 for educational services to -0.1 for social assistance, compared with 1.9 to 4.9 for industries such as mining, oil and gas, information and professional services.

Finally, we continue to find it especially troubling that the productivity adjustment appears to be applied only when it *reduces* Medicare payments. For example, in FY 2021, the 10-year moving average growth of the productivity factor was forecasted at -0.1%. CMS acknowledged that subtracting a negative growth factor from the market basket would have *increased* it by 0.1 percentage point. However, the agency set the productivity factor at 0, stating that it is required to reduce — not increase — the market basket by changes in economy-wide productivity.⁸ Put simply, the agency uses the productivity factor only when it lowers Medicare spending.

The cumulative, compounding effect of these annual reductions — coupled with the asymmetric treatment of periods of declining economy-wide productivity — has widened the gap between payments and the cost of providing services, leaving providers increasingly underfunded. In light of the above, the AHA continues to have serious concerns about the proposed productivity cut, particularly given the extraordinary pressures under which healthcare providers continue to operate.

REQUEST FOR INFORMATION ON CASE-MIX CREEP

⁸ 85 Fed. Reg. 58797 (Sept. 18, 2020).

The AHA appreciates the opportunity to comment on CMS' RFI regarding "case-mix creep" in the SNF PPS. While we support ongoing evaluation of payment accuracy, we have significant concerns regarding the conceptual methodological approach described in the RFI. CMS' suggested approach to addressing case-mix creep risks revisiting issues that CMS has already addressed, relies on insufficiently transparent methods and misinterprets expected changes following implementation of the PDPM.

To begin, we are concerned that the RFI revisits an issue that CMS has already examined and addressed through prior policy decisions, namely the parity adjustments implemented in the first years of the PDPM. Specifically, the agency previously analyzed how provider behavior changed under the PDPM and, as a result, cut payments to, as it says, maintain budget neutrality. Yet, this RFI effectively seeks to readdress the issue — using a different analytical method — and add more cuts based on the same purported underlying behavioral changes. Doing so would impose a second, duplicative cut.

More specifically, as CMS has explained across multiple rulemakings, the PDPM fundamentally restructured SNF payment by shifting incentives toward patient characteristics and clinical complexity rather than therapy volume. Upon its implementation, the agency instituted multiple years of parity adjustments to, as it stated, address changes in case mix and align payments with the new system.⁹ The behavioral changes CMS is seeking feedback on in this RFI, including shifts in coding intensity, documentation practices and case-mix distribution, are the same changes that the agency has already addressed. Revisiting these in the context of a new adjustment would reduce payments a second time for a single set of changes that the agency has already made. Accordingly, any evaluation of potential residual coding changes must, at a minimum, be limited to periods after the parity adjustments were fully implemented.

In addition, the RFI describes a methodology that is grounded in assumptions that are not well supported. For example, CMS' regression framework attempts to distinguish "real" changes in patient acuity from "nominal" coding changes by assuming that pre-PDPM trends "would have continued in FY 2020 and onward regardless of the implementation of PDPM."¹⁰ That assumption is not reliable in the context of a major payment reform designed specifically to change care patterns, documentation and classification incentives. This is especially true because this period includes the COVID-19 public health emergency, which creates unique difficulties in isolating trends and behavior. Similarly, CMS identifies divergence between case-mix index and measured costs as evidence of potential "nominal" change, noting that the case-mix index has

⁹ Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023, 87 Fed. Reg. 47502; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024, 88 Fed. Reg. 53200.

¹⁰ Acumen Technical Memo, March 2026.

increased while median costs per day have decreased.¹¹ Yet this comparison relies on incomplete cost proxies — including a complete absence of nursing cost data — and does not fully account for changes in patient mix, referral patterns or broader system dynamics. As a result, the analysis does not appropriately isolate coding behavior from real-world changes in the SNF patient population.

In addition, the RFI appears to treat early changes following PDPM implementation as inherently suspect. However, changes in coding and documentation in the initial years of a new payment system are expected and appropriate. Indeed, CMS designed the model to change provider incentives and promote more accurate, patient-centered classification. As the agency explained, PDPM “improves the overall accuracy and appropriateness of SNF payments by classifying patients... based on... patient characteristics.”¹² As such, PDPM required providers to shift from documenting therapy utilization to capturing clinically relevant patient characteristics, including comorbidities, functional status and cognitive conditions. In that context, increases in reporting certain conditions — such as malnutrition, swallowing disorders or depression — are consistent with providers complying with the new payment system, not engaging in inappropriate coding behavior. In fact, CMS has long emphasized that patient assessment data are designed to capture clinical and functional status data elements that form the foundation of accurate classification and payment. Improvements in the completeness and accuracy of that information should be understood as strengthening, not undermining, the integrity of the payment system. In other words, changes in coding and case mix are not only expected but central to achieving the model’s goals. Reducing payment because providers have adapted to these incentives sends a conflicting signal. It also risks undermining the improvements PDPM was designed to achieve.

For these reasons, we urge CMS not to pursue additional adjustments based on the RFI framework. At a minimum, CMS should (1) limit any evaluation to post-parity adjustment periods and (2) clearly distinguish between inappropriate coding behavior and expected system adaptation. Absent these steps, further action risks duplicating prior adjustments, mischaracterizing appropriate provider behavior and reducing payment accuracy under the SNF PPS.

WAGE INDEX POLICIES AND REQUEST FOR INFORMATION ON A SNF-SPECIFIC WAGE INDEX

For FY 2027, CMS proposes to continue to use the inpatient PPS wage index to adjust SNF payments, specifically employing the relevant pre-floor, pre-reclassification inpatient hospital wage index. However, the agency also solicits comments on whether it should consider using alternative data sources, such as SNF cost reports or Bureau of Labor Statistics (BLS) wage data, to construct an SNF-specific wage index for potential use in future years.

¹¹ Acumen Technical Memo, March 2026.

¹² Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027, 91 Fed. Reg. 17682

The AHA has conducted extensive policy work on the wage index. It is a difficult issue without a consensus solution. For example, using SNF cost reports to construct a SNF-specific wage index would be very burdensome for both SNFs and CMS itself. It also would create a system that is circular and self-perpetuating. Specifically, using only SNF data to set the wage index would mean that SNFs could influence their own wage index values. This could lead to a problem where SNFs with low wage indices may be unable to increase wages to become competitive in the labor market.

Policymakers also have considered using BLS data to calculate the wage index. The AHA and our members have examined these data closely and found that, while their collection and use may be significantly less burdensome, they have critical shortcomings. For example, BLS data exclude the cost of benefits. However, benefits are an important component of the wage index because the portion of total compensation attributable to benefits varies systematically. If benefits were excluded, the wage index would be understated in areas where benefits account for a greater portion of compensation; it would similarly be overstated in areas where they account for a lower portion. Therefore, any adjustments made to include benefit costs would have to be market-specific. In addition, if hospital-specific benefit information is to be added, it would have to be collected on CMS' Medicare cost report. Yet doing so would add regulatory burden as well as some degree of circularity back into the system.

In addition, BLS data are derived from voluntary surveys and a sample of employers. Estimates using a sampling methodology like the BLS approach would be less reliable than using the entire universe of cost reports. CMS' current process in calculating the inpatient PPS wage indices, and therefore presumably any new process for IRF wage indices, allows for extensive public scrutiny of the data while the BLS approach does not. Unlike CMS' public process for review and correction of cost report wage data, BLS has a strict confidentiality policy. Hospitals would thus be unable to verify the accuracy of the data.

BLS data also include data on the wages of healthcare workers employed in all industries. For example, healthcare sector data from hospitals, physician practices, skilled-nursing facilities, ambulatory surgical centers, home health agencies and hospices are all included. Yet, SNFs differ from the universe of all employers in terms of the wage levels necessary to recruit and retain qualified employees, the percentage of compensation paid in benefits, the likelihood of unionization and other factors that affect compensation rates.

Finally, we urge CMS to consider whether it would need to create a system for reclassifications of SNFs to a different labor market. Labor markets cannot realistically be defined as hard boundaries, and certain adjustments to the wage index may be necessary to accurately capture differences in labor costs across SNFs. However, our members have expressed concern that the number of reclassifications and exceptions permitted under the current inpatient PPS is complex and confusing.

SNF QUALITY REPORTING PROGRAM (QRP)

Removal of COVID-19 Vaccination Measures. Beginning with the FY 2028 SNF QRP, CMS proposes to remove two measures related to vaccination against COVID-19: Coverage Among Healthcare Personnel and Percent of Patients/Residents Who Are Up To Date. The AHA supports the removal of these measures from the program, as it would align the SNF QRP with other CMS quality reporting programs from which these measures have already been removed.

Minimum Data Set (MDS) Data Submission on All SNF Residents. Beginning with residents admitted on Oct. 1, 2029 (for purposes of the FY 2031 SNF QRP), CMS proposes to require SNFs to submit MDS data on all SNF residents regardless of payer. SNFs would submit these data on all non-Medicare FFS SNF residents at admission and discharge using the Nursing Home PPS and the Nursing Home Part A PPS Discharge assessments, and the corresponding Swing Bed assessments. CMS would apply the same data submission requirements for MDS assessments for non-Medicare FFS residents, including a data completeness threshold of 90% of the MDS assessments submitted containing 100% of the required data, as well as the data submission deadlines. SNFs that do not submit this data would have their annual payment update for the fiscal year reduced by 2 percentage points.

While CMS proposes that patients for whom MDS data must be submitted would be those who match the definition of requiring skilled services as described in the Medicare Benefits Policy Manual, the AHA is concerned that the overlap and frequent change in status of patients who are served by SNFs could result in confusion and inadvertent noncompliance by facilities. Many SNFs comprise multiple types of service settings and can provide both long-stay and short-term care that may or may not be skilled. Patients also may change in their needs, or may be transferred or discharged and readmitted several times during a reporting period. If this proposal is finalized, we urge CMS to provide training and clearly written instructions to SNFs to ensure that they are not taking on the unnecessary burden of data collection, management, and storage to comply with data submission requirements, as well as not risking their payment updates.

Revision of Data Submission Timeline. Beginning with the FY 2029 IRF QRP, CMS proposes that SNFs must complete their data submissions and make any corrections to their MDS assessment data no later than the 15th day of the second month after the end of the calendar quarter. If this day falls on a Friday, weekend, or Federal holiday, the date would be delayed until 11:59 p.m. EST on the next business day. Currently, SNFs have approximately 4.5 months (135 days) after the end of each quarter to submit SNF QRP data; this proposal would allow for approximately 45 days for data submission for both assessment-based data and data submitted through the National Healthcare Safety Network (NHSN).

The Honorable Mehmet Oz, M.D.

June 1, 2026

Page 9 of 9

AHA's members work hard to meet the existing data submission deadlines, and, as CMS notes in its analysis, approximately 97.18% of MDS assessments were submitted to CMS within a 45-day timeframe, and 95% of all SNFs submitted NHSN data within a 45-day timeframe. We believe that the shortened timeframe for data submission is likely sufficient; however, to ensure consistency and clarity, we suggest that CMS instead consider a clearer deadline. For example, requiring submission by the "last business day of the month," rather than the "15th day of the month," would be simpler for facilities to interpret. In addition, we urge CMS to monitor patterns of data submission leading up to the new deadline and provide adequate notice and assistance to facilities approaching the deadline without having submitted data; for example, reminding them of their options for extraordinary circumstances exceptions. Further, as SNFs would be required to submit MDS data on all SNF residents regardless of payer if this rule is finalized as proposed, CMS should proactively work with SNFs to determine if they are experiencing challenges in managing and submitting larger volumes of data.

The AHA appreciates your consideration of these issues. Please contact me if you have questions, or feel free to have a member of your team contact Jonathan Gold, AHA senior associate director for policy, at (202) 626-2368 or jgold@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development