September 15, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov

Dear Administrator Oz:

On behalf of LeadingAge, which represents more than 5,400 nonprofit aging services providers and other mission-driven organizations, I appreciate the opportunity to offer comments in response to the Calendar Year (CY) 2026 proposed rule CMS-1834-P. LeadingAge, alongside our members and 36 partners in 41 states, uses advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care including Medicare home health agencies. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

While we do not typically comment on hospital outpatient prospective payment rules, we would like to draw your attention to significant impacts the proposal to phase out the inpatient-only (IPO) list will have on Medicare fee-for-service (FFS) beneficiaries' access to skilled nursing facility (SNF) services outside of the hospital setting, beginning with the 285 mostly musculoskeletal procedures proposed for removal in CY26.

The proposal to eliminate the IPO list of procedures over three years fails to consider the fact that this policy also alters a patient's access to SNF care following a procedure.

Under Section 1861(i) of the Social Security Act and 42 CFR 409.30 of the Medicare regulations, traditional Medicare only covers SNF services when a Medicare beneficiary has had a 3-day inpatient hospital stay within 30 days of admission to the SNF. Many of the IPO musculoskeletal procedures have historically met this requirement, allowing individuals to transition to needed skilled care and intensive rehabilitation therapies provided by a SNF. If these procedures are no longer inpatient, then patients will no longer be eligible for SNF services post-procedure.

While we realize physicians are still empowered to determine whether a procedure can be provided either inpatient or outpatient based on the patient's needs, and we agree that it is good practice to defer to the judgment of physicians who are familiar with a patient's health needs, we also worry about pressure being placed upon them to opt for the lower-cost options of providing services outpatient. Medical advancements may support the elimination of procedures from the IPO list, allowing them to be safely provided in an outpatient setting. However, we see no consideration given to the post-procedural support that may still be needed for individuals undergoing these procedures.

LeadingAge SNF members report that anywhere from 20-50% of their current admissions are for Medicare beneficiaries who received musculoskeletal procedures. We believe it is unlikely that the need for SNF services would be completely unnecessary just because a procedure was shifted to an outpatient setting. While some of these procedures may be less invasive, it does not mean that these patients do not continue to need skilled care and the more intensive rehabilitation therapies that a SNF setting offers. While home health agencies could provide more intermittent, in-home Part B therapies, patients do not always have access to such services in their communities and in some circumstances, the individual requires the more-intensive, daily SNF rehabilitation therapies. If CMS takes no action, SNF services would no longer be an available option to Medicare FFS beneficiaries following these procedures because there is no qualifying 3-day inpatient stay.

Specifically, we recommend CMS clarify that individuals who receive procedures previously on the IPO-only list and receive those services on an outpatient basis should remain eligible for SNF services, if deemed necessary by their treating physician.

We recommend that CMS monitor 30-day hospital admissions for all procedures being removed from the IPO list to determine if appropriate decisions are being made and patients' best interests are being served.

Recommendation: LeadingAge recommends CMS pursue the elimination of the outdated 3-day inpatient stay requirement for Medicare FFS beneficiaries to access SNF care as the IPO list is phased out. Only about 20% of Medicare beneficiaries are still subject to this requirement, as those who are enrolled or attributed to Medicare Advantage Organizations or Accountable Care Organizations already have this requirement waived. Eliminating the 3-day stay requirement will likely require legislation to eliminate the requirement in Section 1861 (i) of the Social Security Act and corresponding regulatory changes to 42 CFR 409.30. Therefore, in the interim, we recommend CMS exempt procedures removed from the IPO list from the 3-day inpatient stay requirement if the treating physician recommends SNF care post-procedure. This may require CMS to establish a specific reimbursement code for SNF providers in these circumstances. Absent CMS's ability to take these steps, we ask CMS to delay the phase-out of the IPO list, as we are concerned about the consequences for patient access to SNF care. A delay will allow time to eliminate the barrier to this access, the 3-day stay requirement.

Finally, as CMS continues to re-imagine care delivery for the 21st century, we would be interested in working with CMS staff to imagine a new role for SNFs that leverages their expertise in chronic care management and could reduce Medicare spending, a key goal.

Most nursing homes provide two levels of care: skilled nursing facility care, which today follows a hospitalization, and long-term services and supports as a nursing facility supporting older adults as they age to manage their chronic conditions, support activities of daily living, and address the challenges of declining cognition. Today, SNFs are viewed as a type of rehabilitation provider, but we believe we could also serve as a "stabilization" provider with some imagination and regulatory reform.

As CMS knows, chronic conditions cannot be eliminated once a patient has them, but appropriate interventions and management of these conditions can help the individual maximize their quality of life, avoid unnecessary hospitalizations, and contain Medicare expenditures. Sometimes individuals with chronic conditions encounter a situation that destabilizes their health and requires intervention. However, the situation does not always warrant a hospital-level of care intervention. Instead, it may just require skilled level of care, including 24-hour supervision, intravenous medications or fluids, medication monitoring and support, ensuring a prescribed diet is followed, among other support., which could be provided by a SNF. We envision CMS giving treating physicians the option to directly admit a patient to a SNF when the person needs help

to stabilize aspects of their chronic condition, allowing them to avoid an unnecessary emergency department visit and the associated cost.

We also have heard of cases of older adults receiving other procedures in an outpatient ambulatory surgical center but requiring overnight observation or support as they have no family caregiver who can provide this support. We would like to work with you to make this type of stabilization care possible.

We hope CMS will examine their authority to exempt or waive the 3-day inpatient stay requirement for individuals who receive an IPO procedure on an outpatient basis, allowing them to continue to receive SNF services if prescribed by their treating physician. SNFs could serve a key role in this transition of procedures to outpatient operating as a step-down from the hospital, supporting frail elders post outpatient procedure with the 24-hour observation they need and the intensive therapies to support their recovery to full function faster. SNF services cost less than an DRG for an inpatient hospitalization, and by shifting this post-procedure care to a SNF, hospital inpatient beds can be preserved for patients with acute needs.

Thank you for considering our comments. We look forward to working with CMS to ensure that older adults receive the care they need in the most appropriate setting.

Sincerely,

Nicole O. Fallon
Vice President, Integrated Services & Managed Care
LeadingAge
Nfallon@leadingage.org