June 1, 2026

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

Submitted electronically via https://regulations.gov

Dear Administrator Oz:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Fiscal Year 2027 (FY27) Skilled Nursing Facilities (SNF) Prospective Payment System (PPS) proposed rule: 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 2027. On behalf of more than 2,000 nursing home members, we submit our comments on proposed payment updates, changes to the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) and Value-Based Purchasing (VBP) program as outlined below.

About LeadingAge: We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.

Payment Updates

CMS proposes a 2.4% payment update for FY 27 based on a 3.2% market basket update, less a 0.8% productivity adjustment. LeadingAge generally supports updates to payment policies based on timely data for a more accurate reflection of stable, current conditions. However, we continue to have concern about the inadequacy of long-term care reimbursement. While this rule is specific to post-acute skilled care, the policies in this rule impact both skilled and long-term care since many nursing homes serve both short- and long-stay residents and changes to payment policies impact both skilled and long-term care reimbursement policies.

A 2.4% increase is the lowest proposed increase for SNFs in years. We are concerned that this increase will not adequately capture the increased costs experienced by SNFs. Increases in labor wages and supply costs, coupled with inflation and tariffs, challenge the healthcare sector and in particular our mission-driven nursing home members. This strain on nursing home finances

impacts our ability to improve quality of care and cannot be overlooked. We urge CMS to reconsider payment update policies and work toward policies that support nursing homes with the financial and physical resources needed to meet residents' needs in real-time.

CMS also requests feedback on the development of a SNF-specific wage index. Specifically, CMS requests feedback on data sources that could be used to construct a SNF-specific wage index for potential use in future years.

LeadingAge is supportive of CMS's efforts to explore the development of a SNF-specific wage index. We feel it is important to have an accurate representation of SNF expenses when determining SNF payment updates and the Inpatient Prospective Payment System (IPPS) wage index that is used to calculate SNF PPS rates in the absence of a SNF-specific wage index is, inherently, unable to provide that. SNFs and hospitals are vastly different settings, employing different mixes of workers and utilizing them in different ways. Further, the IPPS wage index includes several exceptions when determining the wage index for hospitals. These exceptions include reclassifications, floors, outmigration, and a low wage exception. Not only are these exceptions not available to SNFs, but they contribute to inaccuracies in the wage index.

With this in mind, we believe the development and timely implementation of a SNF-specific wage index is appropriate. In doing so, we encourage CMS to seek data sources that provide the most accurate representation of the costs of labor in SNFs. Recognizing that data sources like Medicare Cost Reports and Bureau of Labor Statistics data each have both advantages and limitations, we raise the following questions for CMS's consideration.

Does a given type of worker cost the same in all settings? All employers in an area are competing for the same pool of workers. However, setting-specific factors may influence the cost of different staff. For example, SNFs employ more certified nurse aides (CNAs) than hospitals do. CNAs are also used differently in SNFs than they are in hospitals. As SNFs strive to attract CNAs into post-acute and long-term care, the cost of a CNA in a SNF is likely to be different than the cost of a CNA in a hospital or other setting.

What is the best way to define labor market areas? As noted by the Medicare Payment Advisory Commission (MedPAC) in their June 2023 report to Congress, the labor market areas currently used in the IPPS wage index are not sensitive enough to reflect variations in relative wages within labor market areas and across adjacent areas. Sometimes, the defined labor market area is quite large and the cost of labor closer to the core urban area is quite different from the cost of labor on the outer borders of the labor market area. Additionally, employers on the outer borders of the labor market area are conceivably competing for staff with employers in the adjacent labor market area rather than employers on the other side of their own labor market area, but the wage index may be vastly different for the two adjacent labor market areas.

How have recent events challenged traditional assumptions about wage and labor costs? MedPAC notes in the June 2023 report that the IPPS wage index is based on the assumption that wages in rural areas are lower than wages in urban areas. However, as attention to staffing in nursing homes intensifies and the workforce shortage continues, we wonder if that assumption still holds true. Providers in rural areas are not only competing for workers within a limited labor

pool, but they also may be seeking to attract workers from more distant urban areas. It seems reasonable to consider that these factors may result in rural providers paying higher wages out of necessity. Similarly, as more workers are attracted to the relative flexibility of staffing agencies, providers' labor costs are rising as they are forced to pay higher rates for nurses from a staffing agency than they are paying for nurses who live and work in the same area but are employed directly by the SNF.

Lastly, for any future changes to the wage index, we would stress the importance of maintaining the wage index cap that was finalized in the FY23 SNF PPS rule to help smooth the transition from the IPPS wage index by ensuring that no nursing home experiences greater than a 5% reduction in wage index.

Request for Information: Methodology for Quantifying and Addressing Case-Mix Creep Under the Patient-Driven Payment Model

When CMS finalized the Patient-Driven Payment Model in FY 19, it was intended to be implemented in a budget neutral manner. Despite finalizing a parity adjustment in FY 23 that was phased in over the course of two years, CMS observes that PDPM continues to cost more than intended. CMS has identified certain trends in case-mix that they believe have led to these higher costs and CMS does not feel that the changes in coding and classification reflect real changes in the case-mix of SNF residents. CMS contends that the data suggest "significant increases in certain case-mix indices that are unlikely to reflect underlying health status trends in the patient population." CMS has coined this "case-mix creep" and has developed a regression framework to quantify this observed trend.

The framework includes examining changes in case-mix groups and case mix-indices according to three components: Real Population Health and Utilization Changes, Real Time Trends, and Nominal Change. CMS then evaluates case-mix indices from FY 2020 to FY 2024 to establish two values. The first value, Average Actual CMI, reflects the actual case-mix index that occurred after adjusting for parity using all three components. The second value, Average Target CMI, represents the estimate case-mix indices over the same time period according to the same factors, but removes "Nominal Change" to account for the "case-mix creep". The ratio of these two values is determined to be the Case-Mix Creep Adjustment Factor, which is then applied to each of the five components of PDPM: physical therapy, occupational therapy, speech/language pathology, non-therapy ancillary, and nursing.

LeadingAge does not support the application of a case-mix creep adjustment factor. While CMS has observed changes in coding behavior since the implementation of PDPM, we do not agree that these changes are a result of "upcoding". We believe these nominal changes are better explained by improved accuracy in assessment and coding of patient conditions. In the months leading up to the implementation of PDPM, CMS provided a great deal of education and training to providers to ensure they understood the new payment model. This included emphasis on the importance of accurately assessing residents' needs, coding appropriately on the Minimum Data Set (MDS), and aligning services to better meet these needs. As CMS intended, SNF providers switched the focus of SNF care from one heavily focused on rehab therapy to a more holistic approach that was more precisely tailored to the needs of the resident. Rather than the blunt tool

of resource (rehab therapy) utilization, the precision tool of PDPM gave providers more unique combinations of services, considering multiple factors contributing to wellbeing, to meet the unique needs of each individual seeking post-acute, skilled care.

Understanding this shift in focus and approach to care, it is unsurprising that healthcare utilization costs increased under PDPM. It is also short-sighted of CMS to call this upcoding and penalize providers by reducing payment. Nursing home providers are accurately assessing and coding the needs of residents. This coding then translates into actual provision of care that benefits the residents by meeting their needs and supporting their goals for care. For example, CMS notes in the proposed rule a 17% increase in coding for swallowing disorder. Swallowing disorder requires interventions. While speech/language pathology is one intervention, which has reportedly decreased since the implementation of PDPM, there are other non-therapy interventions that residents could be provided such as adjustments to diet textures, thickening of liquids, or cueing for the use of swallowing techniques. If CMS were to apply a case-mix adjustment factor, they would be paying nursing homes less for providing the same care – a move that is truly unjustifiable. Do not short-change nursing home providers to compensate for the ways in which CMS failed to anticipate the impact of a new payment model.

SNF Quality Reporting Program

CMS proposes several changes to the SNF Quality Reporting Program in this rule. CMS proposes the removal of two quality measures for FY 28: COVID-19 Vaccination Coverage Among Healthcare Personnel and COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date. CMS proposes removing these measures based on removal factor 3, measure does not align with current clinical guidelines or practice. CMS explains that when these measures were adopted into SNF QRP, vaccination recommendations were different and more clear-cut. Current vaccine recommendations from CDC are based on shared clinical decision-making, meaning that there is no single default recommendation to vaccinate a defined population and both vaccination and non-vaccination may be consistent with the application of shared clinical decision-making.

LeadingAge supports removal of these two measures from SNF QRP. LeadingAge has maintained since their introduction that these measures are not a reflection of the quality of care in a nursing home but rather a reflection of the personal choices of healthcare personnel and of residents and their families and as such, are inappropriate as "quality measures". We support no longer requiring nursing homes to report this data through the National Healthcare Safety Network for staff and the removal of this measure from the MDS.

CMS also proposes to revise deadlines for submission of MDS data for the SNF QRP from 4.5 months after the end of each quarter to the 15th day of the second month following each quarter. CMS contends that, based on 2024 data, 97.18% of MDS assessments were already being submitted within the 45-day timeframe. Revising this timeframe would make submission deadlines consistent with other data submission timeframes and would allow for SNF QRP data to be publicly reported on Nursing Home Care Compare more quickly.

LeadingAge supports revision of data submission deadlines for SNR QRP to the 15th day of the second month after the quarter ends. Considering that the vast majority of MDS assessments are already submitted within this timeframe, we believe this revision will present no additional administrative burden on most providers and will make the public display of SNF QRP data more meaningful. Our members have previously expressed concern that quality measures displayed on Nursing Home Care Compare are outdated. This outdated data fails to give an accurate picture of the quality of care being provided in the nursing home and could impact choices of potential consumers, hospitals, and other referral sources, or could impact participation in Accountable Care Organizations. Revising timelines will not only allow for more accurate assessments of nursing home quality but will also benefit providers seeking to use this data in quality improvement activities.

CMS additionally proposes to expand SNF QRP to include data from all SNF patients regardless of payer beginning with FY 2031 SNF QRP. This means that SNFs would be required to submit MDS data for all SNF residents regardless of payer beginning with residents admitted on October 1, 2029. CMS notes that data submission on all patients regardless of payer is currently required in several other programs including the Home Health QRP and Hospice QRP. They also note that Medicare Advantage enrollment in 2025 was estimated to be 54% of all Medicare beneficiaries meaning that, according to current program requirements, SNF QRP measures are based on data from fewer than half of all beneficiaries receiving SNF care.

Recognizing that a standard definition would be required to properly identify the residents for whom data must be submitted, CMS has proposed using an adapted version of the definition of skilled services from the Medicare Benefits Policy Manual. Specifically, CMS proposes that SNFs would submit MDS data on residents regardless of payer source when all of the following four criteria are met:

- The resident is admitted to the SNF for covered skilled nursing services or skilled rehabilitation services.
- The resident requires these services on a daily basis.
- The daily skilled services can be provided only on an inpatient basis in a SNF.
- The services delivered are reasonable and necessary for the treatment of a resident's illness or injury.

LeadingAge supports the proposal to expand SNF QRP to include all SNF patients regardless of payer source. As CMS notes, SNF QRP measures are currently based on data from fewer than half of all patients that receive these services. We feel it is important for the SNF QRP to be as accurate and representative of the total picture of SNF care as possible. We are concerned, however, about the additional burden on nursing homes that this expansion would cause – some nursing homes would now be submitting MDS assessments for patients for whom they were not previously completing assessments. We recommend that CMS take additional steps to work with other payers, including Medicare Advantage plans, to identify ways to lessen burden on providers, such as utilizing existing MDS assessment data for billing purposes rather than requiring additional, unique assessments or documentation.

SNF Value-Based Purchasing Program

CMS is proposing to revise the snapshot dates by which providers must submit any corrections to MDS data used to calculate SNF VBP measures. Based on the proposal to revise MDS data submission timeframes, CMS proposes to revise snapshot dates to the 15th day of the second month after the end of the period for two measures: Falls with Major Injury (Long-Stay) and Discharge Function.

LeadingAge supports these changes. We support the revision of the MDS submission timeframes and therefore support revising snapshot dates to align with data submission timeframes for these two SNF VBP measures.

Thank you for your consideration of these comments. If you have any questions, please reach out to Jodi Eyigor jeyigor@leadingage.org for more information.

Sincerely,

Jodi Eyigor
Vice President, Health Policy