MEDPAC | Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Betty Rambur, Ph.D., R.N., F.A.A.N., Vice Chair
Paul B. Masi, M.P.P., Executive Director

June 9, 2025

Dr. Mehmet Oz, M.B.A., M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1827-P

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026" in the *Federal Register*, vol. 90, no. 82, p. 18590 (April 30, 2025). We appreciate CMS's ongoing efforts to administer and improve the payment system for skilled nursing facilities (SNFs), particularly given the many competing demands on the agency's staff.

Our comments focus on three issues:

- The proposed update to the fiscal year (FY) 2026 SNF payment rates,
- The SNF Quality Reporting Program (QRP); and
- The SNF Value-Based Purchasing (VBP) Program.

Market basket update factor for FY 2026, forecast-error adjustment, and productivity adjustment

CMS proposes to increase the SNF payment rates by 2.8 percent. This reflects a 3 percent SNF market basket update minus a 0.8 percentage point total-factor productivity adjustment (both required by law), plus a 0.6 percentage point forecast-error adjustment. Since 2003, CMS has adjusted the market basket percentage update to reflect forecast error if the difference between the forecasted and actual change in the market basket exceeds a specified threshold (0.5 percentage point). At the time of the final rule for FY 2024, using the most recently available forecasted data, CMS finalized an increase in the SNF market basket of 3.0 percentage points. Since updated data indicate that the actual market basket increase was 3.6 percentage points, CMS proposes to increase the market basket update for FY 2026 by 0.6 percentage points.

Comment

The Commission understands that by law CMS is required to update the SNF prospective payment system (PPS) rates by the market basket minus a productivity adjustment. However, we note that after assessing indicators of Medicare's fee-for-service (FFS) payments to SNFs—including beneficiary access to SNF care and SNFs' aggregate Medicare margins—the Commission recommended in its March 2025 report that the Congress reduce the 2025 Medicare base payment rates by 3 percent for FY 2026.[1] Not including federal relief funds, the aggregate FFS Medicare margin for freestanding SNFs in 2023 was 22 percent, the 24th consecutive year that this margin has exceeded 10 percent. The high margins indicate that a reduction is needed to more closely align aggregate payments to aggregate costs.

Although CMS is required by statute to update the payment rates each year by the estimated change in the market basket, the agency is not required to make automatic forecast-error corrections. Consistent with the Commission's comments on prior proposed rules (for FY 2008, FY 2022, FY 2023, FY 2024, and FY 2025), we do not support forecast-error adjustments for two reasons. First, in some years, the forecast-error correction results in making a larger payment increase in addition to the statutory update, even as the aggregate FFS Medicare margin is high. Second, the adjustment results in inconsistent approaches to updates across settings: Except for the updates to the capital payments to acute care hospitals, CMS does not apply forecast-error adjustments to any other market basket updates.

SNF Quality Reporting Program (QRP)

CMS is required to provide confidential feedback to SNFs on their performance on the measures included in the QRP, publicly report SNF performance on the measures, and have a process for SNFs to correct the data before it is publicly reported. Providers have about 4.5 months after each quarterly data collection period to complete their data submissions and make corrections where necessary. In the proposed rule, CMS requested information regarding a potential revision to the final data submission deadline, shortening it to 45 days.

Comment

MedPAC supports CMS's proposal to shorten the SNF QRP data submission deadline. This change will help ensure that quality information is available to consumers, providers, and policymakers in a more timely and actionable manner. CMS identified that the time between when data are collected and submitted by providers and when that data are publicly reported is about nine months. In a CMS October 2024 listening session on expanding the Minimum Data Set (the patient assessment used in nursing homes and SNFs), some participating facilities said that the QRP measure results were not useful for

[1] Medicare Payment Advisory Commission. 2025. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

their quality improvement efforts due to the age of the data.[2] MedPAC agrees that timely data would better assist SNFs in focusing their improvement activities that ultimately could improve patient care.

This 2024 listening session built upon a prior discussion in an August 2023 listening session conducted by Acumen LLC that included a discussion of the utility of collecting more detailed payer information. MedPAC supports gathering detailed payer source information in the MDS. These data would enable the stratification of SNF quality measures by payer (such as Medicare Advantage and Medicaid), enhance transparency, support more nuanced benchmarking, and inform targeted quality-improvement and payment-model evaluations. In the 2023 listening session on the possible expansion of MDS data submission, several representatives from participating SNFs stated that it would be useful to add a field to identify the payer source, such as the data item A1400 that CMS uses to gather payer information in other settings.[3] Patient assessments used by long-term care hospitals, inpatient rehabilitation facilities, and home health agencies require providers to complete detailed payer information. In the past, commenters raised concerns that collecting accurate payer information is challenging because the payer can change during a stay and the information gathered from the referral source, the MDS coordinator, and the SNF business office may be inconsistent. To minimize the reporting burden while gathering accurate information, CMS should work with providers to specify the question(s) to add to the MDS and the process providers would use to verify the information.

In CMS's discussion of future measure concepts, the Commission did not see a discussion of plans to move forward with a measure of patient experience. In the SNF proposed rule for FY 2024, CMS proposed adopting a patient-experience measure but opted not to implement this provision.[4] In 2025, CMS requested information on patient-experience measures and stated it would consider the comments in future measure development.[5] Given that patient experience is a critical dimension of quality, the Commission urges CMS to finalize its approach to gathering this information. In 2021, the Commission recommended that CMS move forward with finalizing the development of patient-experience measures for SNFs and begin to report them.[6] The Commission noted that the

---

[2] RTI International. 2024. *Skilled nursing facility (SNF) QRP listening session summary: Possible expansion of MDS data submission to all SNF residents regardless of payer*. Report prepared for the Centers for Medicare & Medicaid Services. Research Triangle Park, NC: RTI International. https://www.cms.gov/files/document/snfallpayerlisteningsession2024summaryreportv3508.pdf.

[3] Acumen LLC. 2023. *Skilled nursing facility (SNF) QRP listening session summary: Possible expansion of MDS data submission to all SNF residents regardless of payer*. Report prepared for the Centers for Medicare & Medicaid Services. Burlingame, CA: Acumen. https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf.

[4] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. 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. Proposed rule. *Federal Register* 88, no. 68 (April 10): 21316–21422.

[5] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. 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 2025. Final rule. *Federal Register* 89, no. 151 (August 6): 64048–64163

[6] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

measure of patient experience should be publicly reported and included in the measure set for the SNF VBP.

SNF Value-Based Purchasing Program (VBP): Removing the health-equity adjustment from the scoring of SNF performance

The SNF VBP program creates incentives for providers to furnish high quality of care. It adjusts upward (a "reward") or downward (a "penalty") the daily payment rates under the prospective payment system based on a provider's performance on the quality measures included in the program. In the FY 2024 final rule, CMS added a health-equity adjustment (HEA) that, beginning in FY 2027, would increase the VBP payments for SNFs that provide high quality of care (top performers, defined as the top third of the distribution of the measure results) and care for high proportions of low-income beneficiaries (defined as having at least 20 percent of their resident populations being dually eligible for Medicare and Medicaid).

In this year's proposed rule, CMS intends to remove the HEA from the scoring of SNF performance. CMS said the removal would improve SNFs' understanding of the VBP program and provide clearer incentives for SNFs to improve the quality of their care. CMS considered altering the structure of the adjustment methodology to simplify it but said this would take time to test and develop and, if pursued, would be addressed in future rulemaking.

Comment

In its June 2023 comment letter on the proposed HEA, the Commission supported CMS's efforts to account for differences in the social risk of provider patient populations in the VBP scoring.[7] Though structured differently, the HEA is consistent with one of the Commission's principles of quality measurement in the Medicare program: The program should take into account, as necessary, differences in a provider's patient population, including social risk factors.[8] Providers that treat higher proportions of patients with dual eligibility may face greater challenges to success in a quality payment program because it may be harder for them to achieve good outcomes for their patients. A quality payment program, such as the SNF VBP program, should account for differences in the providers' patient populations to counter the challenges they could face in achieving good outcomes.

If the HEA is removed, the Commission encourages CMS to consider an alternative design that the Commission recommended in its June 2021 report.[9] We recommended that the Congress eliminate Medicare's current SNF VBP and establish a new SNF value incentive program that accounts for differences in patient social risk factors using a peer-grouping

---

[7] Medicare Payment Advisory Commission. 2023. Comment letter on CMS's proposed rule on skilled nursing facilities. June 2. https://www.medpac.gov/wp-content/uploads/2023/06/06022023_SNF_FY2024_MedPAC_comment_SEC.pdf.
[8] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[9] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

approach. In this design, Medicare would make adjustments to payments based on a provider's performance compared with providers with similar mixes of patients at high social risk (that is, its "peers") to determine the penalties or rewards based on its performance. Medicare would continue reporting unadjusted performance so that patients and other stakeholders would have information to inform their decisions. In its report to the Congress, the Commission included additional considerations for how to structure the SNF VBP.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair