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Medicare Payment Advisory Commission
Washington DC

Submitted electronically: meetingcomments@medpac.gov

Dear Chairman Navathe

Please accept this public comment in response to the October 9, 2026 MedPAC meeting:

Assessing the accuracy of the skilled nursing facility and home health prospective payment systems
ISSUE: *In 2019 and 2020, CMS implemented major revisions to FFS Medicare's skilled nursing facility and home health prospective payment systems.*
KEY POINTS: *Understanding the accuracy of these new payment systems is important both to ensure beneficiary access to care and to evaluate program (and taxpayer) spending.*
ACTION: *Commissioners will review and discuss the workplan.*

The Center for Nursing Value, Inc. (CNV) is providing feedback regarding employment patterns and costs of registered nurses (RN), licensed practical nurses (LPN) and nursing assistants (NA) working in home health care services (HH) and skilled nursing facilities (SNF) with a specific focus on SNFs. We highlight current data to examine how nursing case-mix index (NCMI) data can be utilized to gain clearer insights into resident complexity, payment accuracy, beneficiary access to care, and coding practices across the nursing care team, specifically RNs, LPNs, and NAs.

Background

Table 1 provides the latest Bureau of Labor Statistics (BLS) 2025 employment data and wages. Note, total wages are calculated as base hourly rate plus benefits.

- There were an estimated 142,270 RNs, 188,210 LPNs, and 534,270 NAs employed in SNFs for a total of \$74.8 billion in salary expenditures.
- There were an estimated 198,180 RNs, 80,990 LPNs, and 70,770 NAs employed in HH for a total of \$44.3 billion in salary expenditures.
- Combined HH and SNF, nursing care is estimated to be 1,214,690 employees (RN, LPN, NA) with a combined salary expenditure in 2025 of \$200.9 billion.

Table 1. Bureau of Labor Statistics 2025 Data for RN, LPN, and NA Employment and Wages¹⁻³

29-1141 Registered Nurse				29-2061 Licensed Practical Nurse				RN + LPN		31-1131 Nursing Assistant				RN+LPN+NA	
Employment (FTE)	3,379,720			648,410							1,448,910				
Wage (/hr)	50.14			32.24							20.53				
Wage+Benefits (/hr)	76.69			49.30							29.50				
Industry (Setting)	Employment	Pct	\$ (Billion)	Employment	Pct	\$ (Billion)	Total \$ (Billion)	Pct	Employment	Pct	\$ (Billion)	Total \$ (Billion)	Pct		
General Medical Surgical Hospitals	1,902,960	56.3%	303.6	89,620	13.8%	9.2	312.7	51.6%	442,820	30.6%	27.2	339.9	48.9%		
Offices of Physicians	232,420	6.9%	37.1	69,250	10.7%	7.1	44.2	7.3%		0.0%	-	44.2	6.4%		
Home Health Care Services	198,180	5.9%	31.6	80,990	12.5%	8.3	39.9	6.6%	70,770	4.9%	4.3	44.3	6.4%		
Outpatient Care Centers	173,380	5.1%	27.7	38,950	6.0%	4.0	31.7	5.2%		0.0%	-	31.7	4.6%		
Skilled Nursing Facilities	142,270	4.2%	22.7	188,210	29.0%	19.3	42.0	6.9%	534,270	36.9%	32.8	74.8	10.8%		
Assisted Living Facilities				44,100	6.8%	4.5	4.5	0.7%	161,150	11.1%	9.9	14.4	2.1%		
All Other Settings	730,510	21.6%	116.5	137,290	21.2%	14.1	130.6	21.6%	239,900	16.6%	14.7	145.3	20.9%		
Total	3,379,720	100.0%	539.1	648,410	100.0%	66.5	605.6	100.0%	1,448,910	100.0%	88.9	694.5	100.0%		

This represents a substantial amount of nursing labor and costs expended for residents and beneficiaries in both SNF and HH settings. While payment for resident care in SNFs is adjusted using a nursing case-mix index (NCMI), there is minimal information about the actual nursing labor resources and associated costs provided to each resident. This point is referenced in the Acumen study that was the basis for the Patient Driven Payment Model (PDPM)⁴:

Estimating nursing costs [in SNFs] presented unique challenges. Unlike therapy and NTA charges, nursing charges are reported on SNF claims as part of routine revenue centers, which does not permit researchers to isolate nursing charges from routine services. The relevant literature and data confirm that nursing charges are included in routine cost centers. The Provider Reimbursement Manual states that routine cost centers include “all general nursing services, including administration of oxygen and related medications, handfeeding, incontinency care, tray service, enemas, etc.” Claims data support this finding, as the bulk of non-therapy, non-NTA charges fall in the routine cost centers. Additionally, Acumen discovered that there was very little variation in routine charges per day across residents in a given facility, indicating that facilities did not record resident specific nursing charges (p24).⁵

In the earlier technical expert panel (TEP) review, Acumen found:

. . . that it was difficult to identify resident-specific nursing costs because there is almost no variation in nursing charges on SNF claims. This trend holds throughout a stay, across stays within providers, and between rehabilitation and non-rehabilitation stays (p9).⁶

Also:

. . . nursing charges may be less accurate because charges are not linked to payment. (p9).

The lack of information about care provided by nurses to individual residents in SNFs hides important and clinically meaningful variation in nursing care per resident. This ties directly into nurse staffing levels in SNFs national wide.⁷ Only 5.0% of SNFs, in a national sample study, met minimum proposed RN, LPN, and NA staffing levels in SNFs.⁸ This can and does lead to lower quality of care for those residents in SNFs that are understaffed.⁹⁻¹¹ A study of Medicare claims data from 2018 through 2020 found the PDPM shifted SNF care towards more medically complex patients.^{12, 13} That trend should require more nursing staff and a higher RN skill mix in SNFs.¹⁴ Overall SNF nurse staffing levels and RN levels specifically have declined since the end of the COVID-19 pandemic.¹⁵

The relevant issue for MedPAC is that although the PDPM adjusts for nursing case-mix, indicating the assumption that some residents have a higher need for nursing care due to higher complexity of illness,¹⁶ there is no direct relationship between the NCMI adjusted payment and the actual nursing care delivered to each resident in a SNF. This creates an economic incentive for facilities to provide less nursing care to lower cost margins, and potential for facilities to upcode the NCMI to receive higher payment.¹⁷ This is not a problem isolated to SNFs, but to any healthcare setting that provides continuous nursing care from admission through discharge such as acute care hospitals, long term acute care, inpatient psychiatric and inpatient hospice settings. The costing and billing of nursing care into flat rate daily room charges is a 100 year old problem.¹⁸

The focus of our public comment addresses the upcoming MedPAC review of the PDPM for SNFs. However, the foundational problem of lack of nursing data at the individual resident or patient unit of analysis related to direct care hours and costs as well as identifying services, interventions, or treatments provided by nurses and related nursing care costs, confounds all payment models across the inpatient spectrum of care.¹⁹

Assumptions

There are several assumptions related to the MedPAC proposed study for SNFs regarding nursing care that should be considered.

- Nursing care by RNs, LPNs, and NAs in SNFs is provided continuously from admission to discharge around the clock every day of the year. This can be measured as nursing care hours per resident per day (HPRD) with recommendations for minimum nurse staffing levels of 3.8 to 4.6 hours per resident per day (HPRD).²⁰
- Higher complexity residents require more nursing care, on average, compared to lower complexity residents. This may increase the need for more RNs relative to LPNs (nursing skill mix) and is directly related to quality of care in SNFs as well as the costs.²¹
- The costs of nursing care per direct care hour are higher for RNs compared to LPNs, and higher for LPNs compared to NAs due to differences in base salary per hour (Table 1). A nursing skill mix that favors more RNs than LPNs are more costly than a lower ratio skill mix, all other conditions equivalent.
- Resident level nursing HPRD, associated costs both per resident per day as well as aggregate resident level costs and total care time per stay, and generally, the nursing skill mix in SNFs providing care are currently unknown.^{5,6}

Payment Accuracy

The CNV identifies several questions MedPAC may want to consider during its upcoming analysis to identify areas related to nursing care in SNF and the link between payment, nursing care provided, complexity of care, and clinical and financial outcomes.

- Does the PDPM accurately reflect differences in nursing care needs of each resident and the actual care delivered as measured by direct and indirect care hours and costs?
- Does the NCMI accurately measure cost differences between residents stratified by NCMI score?
- What is the variability of NCMI by day of stay for each resident and what are the implications for adjusting payment based on NCMI?
- Do SNFs accurately adjust billing for differences in nursing care?
- What are payment levels for similar nursing case-mix categories across SNFs?
- Do SNFs with higher aggregate mean NCMI have higher RN, LPN, and NA staffing levels?

- Should NCMI adjusted payment include employee benefits?

Nursing Case-Mix Index

The NCMI represents a model to understand differences in resident need for nursing care within a SNF (Appendix).²² It is a core component of the PDPM and provides useful information about the nursing care needs of residents in a SNF (Table 2). The NCMI is part of the billing data and provides resident level data that can be useful to MedPAC in its analysis.

- Does NCMI vary over time for each resident and day of stay?
- Does the NCMI identify complexity of nursing care and differentiate nursing care time and costs stratified by NCMI aggregate score?
- Can SNFs be compared across aggregated by resident type or by facility to produce a mean (or median) estimate of the aggregate NCMI?
- Is there a method to use the NCMI to estimate nursing direct care time and costs?
- Can the NCMI be used to predict the nursing skill mix, e.g. relative measure of RNs and LPNs, with higher levels of RN care for higher NCMI score residents?
- Can the NCMI provide a basis for comparing costs and nursing direct care time across similar residents and within each resident across SNFs?

Challenges to the NCMI are:

- The measure does not specifically identify the nursing staff skill mix providing care, e.g. RN and LPN or identify direct and indirect care hours per resident.
- Missing data regarding the amount of nursing care and skill mix of nurses may bias the results of any analysis using claims data.
- There is no validation of the NCMI scores, e.g., direct observation of actual nursing care compared to estimate in the current PDPM. A prior study (STRIVE) reported nursing care time using Resource Utilization Group (RUG).^{23, 24} However this measure has been replaced by the NCMI.
- There is no link between the NCMI adjusted payment and the actual nursing care provided by RNs, LPNs, and NAs. If payment is linked to both NCMI and the actual nursing care provided to each resident, this could be an effective policy strategy to incentivize SNFs to improve nurse staffing levels and minimize economic incentives to increase admission of more complex care patients and decrease the amount of nursing care to improve margins.²⁵

PDPM Case-Mix Components

The distribution of payment by case mix adjusted per diem in Table 2 is adapted from the MedPAC payment basics document.

Table 2. Medicare Daily Base Rates for FY 2027

Location	Nursing	PT	OT	Speech	Ancillary	Non case mix	Total Payment
Urban	135.02	77.46	72.10	28.93	101.87	120.91	536.29
Pct Total	25.2%	14.4%	13.4%	5.4%	19.0%	22.5%	100.0%
Rural	129.00	88.30	81.10	36.44	97.33	123.15	555.32
Pct Total	23.2%	15.9%	14.6%	6.6%	17.5%	22.2%	100.0%

Nursing represents 25.2% (urban) or 23.2% (rural) of the total per diem payment base rate. We post potential analysis questions.

- What is the relationship between nursing payment percent to total SNF nursing labor costs and percent per facility? For example, if the overall nursing labor costs at a facility are higher than the 25.2/23.2% payment percent, do the missing nursing costs represent inaccuracies or biases in the payment formula or costing methodologies, e.g. Medicare Cost Report?
- Do different SNFs have different nursing cost structures, e.g. do for-profit SNFs have lower nursing labor costs due to lower overall nurse staffing or employ more NAs than RNs or LPNs?
- Would direct billing for nursing care time based on cost, or implement specific coding schemes to identify the services, interventions, or treatments by RNs and LPNs provide additional information how nursing care is being implemented within the PDPM? Would such a policy change improve the accuracy of the PDPM?

Additional Comments Related to the Presentation Slides

The following addresses the slide set presentation on Oct 9.

[Slide 5]: Later days in a stay adjusted (lower) to reflect lower average costs:

- Do changes in the NCMI score per resident day support lower average costs for nursing care?
- Is there variation in the NCMI scores by resident characteristics, for example a resident receiving ventilator support, maintain a high NCMI score and related higher cost due to increased nursing care needs throughout the admission?

[Slide 5] Factors for assigning case-mix group

- Are there differences among the case-mix scores for different residents (Table 2), e.g. are there higher OT or PT scores in certain residents compared to the nursing NCMI score?
- Are there other factors from the resident assessment information that influence NCMI scores, for example, do residents with lower functional or cognitive status have higher NCMI scores?

[Slide 8] As resident complexity increases, resident care costs increase; Payments should increase proportionally

- Is this a linear relationship across levels of complexity or do portion of residents consume a disproportionately higher amount of nursing care and related costs compared to other residents?
- Is the NCMI a valid and reliable estimate of nursing care complexity?

[Slide 8] Inaccurate payments create financial incentives for providers to code cases in ways that do not reflect resident complexity —> raises program payments unnecessarily.

- Are SNFs miscoding the NCMI to produce higher levels of payment?
- Are SNFs not increasing the amount and skill mix of RNs and LPNs proportional to increases in NCMI score for more complex residents? This reiterates the issues mentioned above, in that SNFs have two strategies to improve facility margins by raising NCMI scores or decreasing the amount and skill mix of nursing care relative to the NCMI score. Are there supporting data for either issue?

Resident selection:

- Are there differences in NCMI among different types of SNFs such as for-profit vs non-profit; urban vs rural; large vs small facilities, etc.?
- From a resident access standpoint, can the NCMI identify SNFs that provide cancer care, dialysis, or ventilator support? Are there regional differences in access to these and other services?

Key Points

- The lack of resident level daily nursing care data in the NCMI presents significant challenges to determine the accuracy of the PDPM.
- Separate nursing data including direct and indirect RN, LPN, and NA care hours and costs are not available in the cost report or billing data.
- The NCMI provides a basis for measuring differences in nursing care needs for SNF residents, however there is no current link or method to determine if the NCMI adjusted payment to SNFs results in higher per diem nursing direct care hours or higher RN skill mix for more complex residents, therefore SNFs may be decreasing both the overall number of nursing staff or skill mix of RNs, LPNs, and NAs to improve margins.

Recommendations

- Consider analyzing the study by Harrington and colleagues that map direct nursing care hours to the PDMP nursing case-mix categories to understand the effects of nurse staffing and skill mix levels by direct costs.¹⁴
- Consider policy changes to amend the Medicare Cost Report for SNFs to identify direct care nursing time and estimated costs per resident per day of stay.²⁶
- Explore opportunities to bill for nursing care separately in SNFs from the daily room charge.¹⁹
- Identify methods to link payment for SNF nursing services to the actual care provided guided by the NCMI as the estimated or expected level of nursing care.

The Center for Nursing Value appreciates the opportunity to provide feedback on this topical area. We welcome dialog to provide additional feedback as the MedPAC study moves forward. If there are any questions regarding our public comment, please contact us at the email below.

Appendix: Nursing Case-Mix Index Components²²

Table 3. Case-Mix Factors for SNF prospective payment

Nursing	Physical therapy	Occupational therapy	Speech–language pathology services	Nontherapy ancillary services
Broad clinical condition or special care	Primary reason for SNF care	Primary reason for SNF care	Neurology/non-neurology case-mix groups	Comorbidities
Extensive services	Functional status	Functional status	SLP-specific comorbidities	Special treatment
Functional status			Cognitive status	
Depression			Difficulty swallowing or requiring mechanically altered diet	
Number of restorative nursing service				

Table 4. NCMI Nursing Care Categories

Special care	Extensive services	Special treatments
Daily insulin injections	Tracheostomy or ventilator care while a patient	Tube or parenteral IV feeding or IV medications
Parenteral or intravenous (IV) feeding	Need for isolation for an active infectious disease while a patient	Tracheostomy care, ventilator or respirator care,
Daily respiratory therapy		Transfusion
Respiratory failure and oxygen therapy while a patient		Radiation
Stage 2+ skin ulcers and selected skin treatments;		Suctioning
Foot wounds with application of dressings		Isolation post admission
IV medications, transfusions, radiation, chemotherapy, or dialysis treatment while a patient.		

Acknowledgements

This public comment was prepared for the Center for Nursing Value by:

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The Center for Nursing Value, Inc. ("The Center") is a nonprofit organization advancing the science and practice of nursing economics through education and advocacy. Through initiatives such as the Fellowship in Nursing Economics (FINE), educational programming, research, and national conversations, we build a community dedicated to strengthening the connection between nursing and healthcare value. The Center envisions a healthcare system where nursing's contributions are fully recognized, valued, and integrated into key healthcare decisions.

Our work connects nursing contributions to the economic decisions shaping healthcare. Through leadership development, education, research, and advocacy, we empower nurses, leaders, policymakers, and organizations to recognize how nursing drives value—and ensure that value is reflected in financial and operational strategies. Providing public comment directly aligns with our organizational mission.

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