MEDPAC | Medicare Payment Advisory Commission

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

Attention: CMS-1843-P

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on 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 2027." We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for skilled nursing facilities (SNFs), particularly given the competing demands on the agency.

Our comments cover three topics:

- CMS's request for information on a methodology for quantifying and addressing "case-mix creep" under the case-mix classification system (the Patient Driven Payment Model, or PDPM),
- CMS's request for comments on the use of alternative data sources to construct a SNF-specific wage index, and
- The proposed requirement that SNFs submit patient assessment data (collected in the Minimum Data Set, or MDS) for all SNF patients regardless of payer.

Methodology to quantify and address case-mix creep under the PDPM

CMS monitors case-mix trends to ensure that payments remain aligned with actual patient acuity rather than changes in coding practices. CMS has found that increases in the reporting of certain MDS elements are unlikely to reflect underlying health status trends and noted the divergence between increases in case mix and declining costs for the therapy and nontherapy ancillary (NTA) components.

CMS proposes a regression framework to separate total case-mix change into: (1) "real population and utilization changes," (2) "real time trends," and (3) "nominal changes." Real population and utilization trends include changes in beneficiary demographics, clinical

conditions, service needs, and system-level utilization patterns. Real time trends include systematic changes over time that occur independent of the PDPM. Nominal changes refer to the observed case-mix growth that may result from changes in coding or classification practices rather than from actual changes in acuity. CMS notes that nominal change is commonly referred to as "case-mix creep."

To estimate the nominal change—or case-mix creep—by case-mix component, CMS compared the average actual case-mix index (CMI) change between fiscal year (FY) 2020 and FY 2024 with the estimated average target CMI. A target CMI accounts for real population and utilization changes and real time trends but removes the nominal shifts in coding. The ratio of the target to the actual CMI is the estimated "case-mix creep adjustment factor." A negative adjustment factor indicates that the actual CMI was higher than the estimated target CMI, which suggests that some of the growth in CMI was due to case mix creep. A positive adjustment factor indicates that the actual CMI was lower than the estimated target CMI, suggesting that case-mix creep did not drive increases in CMI over the period.

CMS estimated case-mix creep adjustment factors for each of the five case-mix components: physical therapy (PT) (+3.3 percent); occupational therapy (OT) (+4.1 percent); speech–language pathology (SLP) (–15.9 percent); nontherapy ancillary services, such as drugs (–1.9 percent); and nursing (–10.6 percent). The estimated total adjustment factor (across all components) is –4.3 percent. CMS requested comments on applying a uniform adjustment to all CMIs or separate adjusters to each component's CMI.

Comment

The Commission appreciates CMS's attention to this important issue in the SNF prospective payment system (PPS) to improve payment accuracy and help ensure beneficiaries' access to care. Without an adjustment, CMIs can reflect coding practices undertaken to boost payments that are unrelated to patients' underlying care needs. In the proposed rule, CMS noted that average CMIs increased at a rate that exceeds what would be expected based solely on changes in patient health status, while median per diem costs declined. This divergence suggests a potential disconnect between reported acuity and observed resource use. Unadjusted CMIs result in inaccurate case-mix weights that unnecessarily raise program payments and lower the value of Medicare's SNF payments. As CMS moves forward, we look forward to seeing the details of the model specification so the approach can be evaluated. We urge CMS to use the most recent data available to quantify case-mix creep and to adjust the CMIs so that CMIs reflect only actual differences in resources needed to treat patients.

Regarding the application of adjustment factors to the CMIs, applying component-specific adjustments to CMIs has several advantages relative to applying an across-the-board adjustment. The estimates of the case-mix creep adjustment factors vary considerably by component. For example, the large negative adjustment factors for SLP and nursing likely reflect the coding practices of certain MDS items such as depression, malnutrition, and difficulty swallowing that raised the actual CMIs above the target CMIs. In contrast, CMS estimated positive adjustment factors for the PT and OT components, indicating that the

actual CMIs were lower than expected. These results are likely due to the overprovision of therapy under the previous case-mix classification system that encouraged the provision of unnecessary therapy and raised the old CMIs. Because the PDPM does not use therapy minutes as a case-mix factor in determining payments, the PT and OT CMIs have declined.

In using an across-the-board adjustment that would be applied uniformly to each component, CMS would not fully correct for estimated coding practices that some providers undertook to boost payments for the nursing and SLP components. For example, the estimated adjustment to the nursing CMIs is –10.9 percent, but an overall reduction would lower the CMI by only 4.3 percent. Applying an adjustment specific to the estimated case-mix creep of each component would better align Medicare's payments with relative costs, thereby making payments more accurate. Adjustments that do not fully reflect the coding creep would result in payments that are higher than warranted based on resource requirements of a beneficiary. These relatively higher payments could encourage providers to selectively admit patients, which could make it more difficult for certain types of beneficiaries to get access to care at SNFs.

When addressing the case-mix creep for individual components, CMS may want to consider whether to make adjustments that most likely reflect the prior undesirable incentives of the pre-PDPM experience, such as the incentive to furnish unnecessary therapy, rather than case-mix creep. The actual case-mix change may reflect more appropriate therapy provision that warrants no correction.

In estimating the case-mix creep adjustment factors, the agency may also want to reconsider the inclusion of data from FY 2020, the height of the impact of the coronavirus pandemic. That period included several changes to Medicare's policies for paying for and covering SNF care that may make experience from that time an undesirable benchmark in this analysis. CMS could update its estimates starting with a later year to mitigate the effects of the pandemic.

We make three final observations regarding the accuracy of the case-mix weights. First, CMS may want to develop a method to make regular updates to the case-mix weights associated with the case-mix groups. Other PPSs include regular updates so that the weights reflect changes over time in resource requirements. Second, while addressing case-mix creep is a good step forward in reestablishing the relative weights *across* the case-mix groups, they do not fully address the aggregate *level* of SNF payments. In our March 2026 report to the Congress, we noted that Medicare's payments have exceeded the costs to treat beneficiaries by at least 10 percent for the past 25 years. Last, when adjustments for coding creep are implemented, it will be important for CMS to monitor the impacts of the changes on patient selection, coding, and staffing (given its key role in shaping SNF quality).

Construction of a SNF-specific wage index

For FY 2027, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

The proposed rule also solicits comments on whether CMS should consider using alternative data sources to construct a SNF-specific wage index for potential use in future years, citing MedPAC's 2023 recommendation for the Secretary to phase in new Medicare wage index systems. CMS seeks feedback to better understand the potential advantages and limitations of using alternative data sources, such as Bureau of Labor Statistics (BLS) data and SNF cost reports, as well as other methodologies that stakeholders believe could appropriately reflect the geographic variation in labor costs for SNFs.

The proposed rule states that, to date, using SNF cost reports to develop a SNF PPS wage index has proven unfeasible. Auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Adopting such an approach would require a significant commitment of resources by CMS and the Medicare administrative contractors (MACs), potentially far more than those required under the IPPS, given that there are nearly five times as many SNFs as there are inpatient hospitals.

Comment

The Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[1] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, SNFs), Medicare needs wage indexes that are less manipulable, more accurately reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor within a given market. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in a new Medicare wage index system for hospitals and other types of providers that:

- Uses all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- Reflects local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- Smooths wage index differences across adjacent local areas.[2]

The Commission supports CMS's initial steps toward constructing a SNF-specific wage index for potential use in future years.

The use of BLS Occupational Employment and Wage Statistics (OEWS) data for core-based statistical area (CBSA)– and occupation-level wage estimates has numerous

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[1]Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC.
[2] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

advantages: This data source is publicly available, recent, and includes all-employer mean wage data. These features would reduce CMS administrative burden, reflect more recent data than the current cost report data that is the basis of the unadjusted hospital wage index, acknowledge that employers in a market compete for similar types of workers, and decrease current circularity that causes deviation between the labor costs reports by hospitals and broader labor market wages.

Establishing SNF-specific occupation weights is also an important feature of this approach and is directionally consistent with the Commission's recommendation. Below are three alternative approaches CMS could consider to calculate the SNF occupation weights; there may be other reasonable approaches as well. Each would involve trade-offs between accuracy, completeness, and administrative burden:[3]

- *Use existing data on salaries from BLS*: While the occupational mix at SNFs may differ from the closest existing North American Industry Classification System category, we believe that using nursing facility data to calculate occupation weights and then applying these weights to all-employer occupation-level relative wages would yield a better approximation of SNFs' variation in labor costs across markets than the current approach of using aggregate wage data from hospital cost reports. Of the three approaches, this one would require the least CMS and provider resources to maintain and update. This is the approach we modeled in our June 2023 report, using data from over 30 occupations.

- *Use existing data on hours from the Payroll Based Journal data.* These data are current, can be verified using facilities' payment records, and include hours worked for about 30 occupations. CMS currently uses these data to calculate nursing homes' star ratings, score facilities in the value-based purchasing program, and review facilities' compliance with state and federal staffing requirements.

- *Use existing and/or new data on freestanding SNF cost reports.* Freestanding SNF cost reports include information on direct care salaries for several occupations but would need to be modified to include additional occupations. We agree with CMS that using (and auditing) SNF cost report data on occupations would be a substantial administrative burden.

Regardless of the alternative wage index data sources used, we urge CMS also to consider the two other parts of our June 2023 wage index recommendation: to account for differences in wages within metropolitan statistical areas (for example, by using data from the Census Bureau's American Community Survey), and to smooth wage index differences across adjacent local areas (such as county lines). We also encourage the agency to estimate the magnitude of changes under an improved wage index and contemplate phasing in larger changes over a period of time.

[3] Depending on the approach CMS takes for occupational mix weights and the units of those weights, the wage index calculation can be modified to accommodate that approach.

Require SNFs to submit patient assessment information on all SNF residents, regardless of payer

CMS currently requires SNFs to submit patient assessment information for fee-for-service (FFS) Medicare beneficiaries using the MDS. CMS proposes to require SNFs to submit MDS data on each SNF resident receiving covered skilled care, regardless of payer, beginning with patients admitted on October 1, 2029. CMS proposes to collect these data for all non-FFS SNF residents at admission and discharge.

Comment

We support the proposed expansion of the collection of MDS data to include non-Medicare FFS residents. CMS previously solicited input on whether to require the collection of MDS data for all SNF patients, not just Medicare FFS beneficiaries, in its proposed rule for FY 2018. In our comment letter on that proposed rule, we noted that the collection of this information would have clear benefits. It would enable comparisons of quality measures derived from MDS data between FFS beneficiaries and other users (including Medicare Advantage enrollees) and inform beneficiaries about the broader quality of the entire facility, especially those who are or are likely to become long-term care residents of the same facility. We note that we had heard from some providers that sorting out FFS status was almost as much work as completing the assessments, so many providers were already assessing all patients.

The expanded data collection would be consistent with the current requirements of the inpatient rehabilitation facility, long-term care hospital, home health, and hospice quality reporting programs.

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