NARA
The National Association of Rehabilitation Providers and Agencies

June 10, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1827-P
Mail Stop C4-26-05
PO Box 8016
Baltimore, MD 21244-8016

Submitted electronically at http://www.regulations.gov

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026 (CMS-1827-P)

Dear Administrator Oz:

The National Association of Rehabilitation Providers and Agencies (NARA) represents more than 90,000 practitioners of physical therapy, occupational therapy, and speech-language pathology through our member organizations. These providers deliver therapy services to Medicare and Medicaid beneficiaries across the United States in a wide range of care settings, including skilled nursing facilities, assisted living facilities, outpatient clinics, hospital inpatient and outpatient departments, beneficiaries' homes, and retirement communities.

As a member-driven organization, NARA is dedicated to ensuring access to care for beneficiaries and advancing the growth and business success of rehabilitation providers through education, support, and advocacy. Our diverse membership gives us a unique and comprehensive perspective on payment and quality programs affecting skilled nursing facilities. Below are our comments on the proposed rule:

Proposed Updates to the SNF Payment Rates

NARA appreciates the 2.8% net increase in payment rates for skilled nursing facilities (SNF) in the proposed rule—marking the third consecutive year of growth. However, we are concerned that this increase falls well short of the 5.06% increase finalized for Medicare Advantage (MA) plans for 2026. This disparity is especially striking given that the MA rate increase for 2026 exceeds those of the prior two years (3.7% in 2025 and 3.3% in 2024).

In the March 2025 MedPAC report,[1] they stated that MA plans higher reimbursement can be attributed to two key factors, favorable selection and coding intensity. First, MA plans can choose where they offer plans and target healthy Medicare beneficiaries in their marketing strategies, although we do recognize there are regulations in place to prevent discrimination and unethical marketing tactics. They can also structure their networks and coverage policies in ways that can effectively limit access for higher-acuity beneficiaries. In fact, a 2024 report from the U.S. Senate Permanent Subcommittee on Investigations (PSI)[2] found that beneficiaries enrolled in Medicare Advantage face serious barriers in accessing care. They found that MA organizations intentionally use prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities. Regarding the second key factor, coding intensity, an OIG report issued in October 2024 identified $3.5 billion in overpayments to MA organizations generated by their use of in-home health risk assessments to increase the number of diagnoses submitted to CMS' MA Encounter Data System.[3] Their findings confirmed that MA organizations systematically drive up their risk adjusted payments by making their enrollees appear sicker than they are. Rewarding MA organizations with a 5.06% increase while SNFs, who provide the necessary care to beneficiaries, receive only 55% of that amount results in a considerable payment imbalance.

This payment imbalance places a significant strain on SNFs to care for increasingly complex patients with fewer resources, while MA plans continue to receive higher payment updates.
We urge policymakers to address this discrepancy to ensure fairness across the system and protect access to high-quality care for all Medicare beneficiaries, particularly those with complex medical needs.

Additionally, while MA plans are receiving these generous updates in payment for beneficiaries from CMS, these increases are not being passed through to the providers delivering the care. MA plans often fail to account for the real-world costs of care—particularly rising labor and inflationary pressures—and typically do not adjust provider reimbursement in step with the CMS-approved increases they receive. In fact, MA plans generally pay one-quarter to one-third less to SNFs than traditional fee-for-service Medicare.[4] This disconnect places significant financial stress on providers and undermines the long-term sustainability of care delivery.

As enrollment in MA plans continues to rise, this issue becomes even more urgent. Providers should receive proportional reimbursement increases when MA plans receive higher payments

[1] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf
[2] https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf
[3] Department of Health and Human Services. Office of Inspector General. Office of Evaluation and Inspections. Medicare Advantage: Questionable Use of Health Risk Assessments Continues to Drive UP Payments to Plans by Billions. October 2024. OEI-03-23-00380. Available at: https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf.
[4] Gleckman, H. The U.S. Predicts Big Increases in Skilled Nursing and Long-Term Care Costs. Forbes. April 4, 2023. Available at: https://www.forbes.com/sites/howardgleckman/2023/04/04/the-us-predicts-big-increases-in-skilled-nursing-and-long-term-care-costs/?sh=525df773b05a.

from CMS. Without corrective action, the growing gap between MA funding and provider compensation will limit access to essential skilled nursing services—particularly for our nation's most vulnerable beneficiaries.

We urge policymakers to work with CMS to revise the MA payment and oversight framework by:

- **Requiring accountability and transparency** in how MA plans allocate CMS funding, including provider reimbursement rates;
- **Incorporating prospective adjustments** for labor shortages and inflation into MA plan payment methodologies Or require that MA plans pass through a minimum % of their annual payment increases to the providers providing the care.; and
- **Establishing mechanisms to ensure provider reimbursement increases proportionally** when CMS increases MA plan payments.

Without such reforms, the integrity of our post-acute care system—and the care options available to millions of seniors—will be increasingly at risk.

Proposed Changes in PDPM ICD-10 Code Mapping

Change from Medical Management to Return to Provider for Diabetes and Eating Disorder. No comment on this at this time since it refers to these codes being primary and the group felt these should not be primary code for admitting to SNF.

Skilled Nursing Facility Quality Reporting Program

While NARA recognizes that the collection of the four standardized patient assessment data elements related to Social Determinants of Health (SDOH) imposes additional administrative burden on skilled nursing facility (SNF) practitioners, we also see value in this information. When used appropriately, these data elements can support more effective interdisciplinary discharge planning by providing critical insights into a patient's home environment and potential barriers to recovery. Incorporating SDOH into the care plan allows providers to develop a more comprehensive, patient-centered approach that improves care coordination and outcomes during the SNF stay and beyond.

Additionally, NARA believes that these data elements would support CMS' interest in the future measure concepts of well-being and nutrition. First, related to the concept of well-being, poor mental health is highly prevalent in people with housing insecurity.[5] The Living Situation item adopted by CMS in the FY 2025 Final Rule would gather that information and provide important insight into a person's well-being. Second, the Food items adopted by CMS in the FY 2025 Final Rule would also provide SNFs with important information about a person's nutritional status. Studies have shown that older adults struggling with food insecurity consume fewer calories and

[5] Carrere J, Vásquez-Vera H, Pérez-Luna A, Novoa AM, Borrell C. Housing Insecurity and Mental Health: the Effect of Housing Tenure and the Coexistence of Life Insecurities. J Urban Health. 2022 Apr;99(2):268-276. doi: 10.1007/s11524-022-00619-5. Epub 2022 Mar 18. PMID: 35303243; PMCID: PMC9033895.

nutrients and have lower overall dietary quality than those who are food secure, which can put them at nutritional risk.[6] Older adults are also at a higher risk of developing malnutrition, which is considered a state of deficit, excess, or imbalance in protein, energy, or other nutrients that adversely impacts an individual's own body form, function, and clinical outcomes.[7] Up to 50 percent of older adults are affected by or at risk for malnutrition, which is further aggravated by a lack of food security and poverty. SNFs and their electronic health record vendors have already done the work to incorporate these items into their software and assessment processes. While we appreciate CMS' desire to decrease burden, SNFs have already spent resources on this policy. Rather than CMS spending additional resources to develop these measure concepts with a new item or a new tool, it would be more efficient to utilize the data items for which CMS and SNFs have already built systems to collect.

RFI: SNF QRP Measure Concepts Under Consideration for Future Years

NARA appreciates CMS's consideration of future measure concepts related to interoperability, well-being, nutrition, and delirium. While CMS has made significant investments to advance interoperability, progress within the post-acute care sector remains limited. The lack of seamless data exchange continues to create inefficiencies and administrative burdens for providers. Improved interoperability—particularly access to standardized data on SDOH and other patient characteristics—has the potential to streamline care coordination and enhance patient outcomes across the continuum.

NARA strongly encourages CMS to prioritize the expansion of interoperability infrastructure in post-acute settings and to identify sustainable funding mechanisms to support implementation. Achieving full interoperability across all care settings is essential to reducing administrative burden and ensuring high-quality, efficient care for Medicare beneficiaries.

NARA members strongly support CMS's commitment to advancing whole-person, person-centered care as outlined in the CMS Strategic Plan. We believe promoting the well-being of patients in SNFs must involve an integrated approach that encompasses physical, mental, and social health. Evidence, including a 2018 study published in the *Journal of Physics*[8], demonstrates that loss of muscle mass and strength contributes to frailty—a condition often exacerbated by malnutrition. Incorporating nutrition as a formal quality measure would align with CMS's efforts to improve health outcomes and reduce disparities by addressing root causes of physical decline in older adults. SNFs are well-positioned to respond to this need (see comments above). Facilities can provide balanced, brain-healthy meals that support cognitive function and holistic well-

[6] Ziliak, J.P., & Gundersen, C. (2019). The State of Senior Hunger in America 2017: An Annual Report. Prepared for Feeding America. Available at https://www.feedingamerica.org/research/senior-hunger-research/senior.

[7] The Malnutrition Quality Collaborative (2020). National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update. Washington, DC: Avalere Health and Defeat Malnutrition Today. Available at *https://defeatmalnutrition.today/advocacy/blueprint/*.

[8] https://iopscience.iop.org/article/10.1088/1742-6596/1073/4/042032/pdf

being, while therapy practitioners develop individualized exercise programs to restore muscle strength and prevent functional decline. These interventions reflect CMS's focus on care quality and coordination across settings.

As people age, the risk of poor nutrition and functional decline increases—yet these challenges are often preventable with the right support systems in place. One effective solution is the wider use of restorative nursing and therapy programs in long-term care. These programs help residents maintain or recover the ability to perform essential daily activities like eating, bathing, and dressing, activities that directly impact nutritional status and well-being. These programs don't just preserve physical function, they protect independence, support emotional well-being, and reduce avoidable hospitalizations and long-term costs. To truly Make America Healthy Again, we must go beyond treating illness and invest in preventive care that strengthens health from the start. Addressing nutrition and physical function early helps avoid more serious, costly conditions later.

Investing in proactive approaches to well-being and nutrition for older adults directly supports the Five M's of Geriatric Care: Medications, Mind, Mobility, Multi-complexity, and what Matters Most, with strong evidence to back their impact. For example, nutritional interventions can decrease hospital readmission rates by 27% and support medication effectiveness by addressing malnutrition, a key driver of poor medication outcomes.[9] Cognitive engagement through physical activity and proper nutrition has been associated with a 35% lower risk of cognitive decline,[10] supporting Mind and well-being. For older adults with multiple chronic conditions, comprehensive lifestyle interventions—including diet and physical activity—have been shown to reduce emergency department visits and improve functional outcomes.[11] In fact, structured physical activity programs have been shown to reduce falls by up to 30%, a critical factor in preserving Mobility and preventing costly injuries and hospitalizations.[12] Most importantly, these programs reflect what Matters Most to older adults: independence, functional ability, and quality of life—core outcomes consistently prioritized in person-centered care models.[13] Embedding these interventions in CMS initiatives, including through the Value-Based Purchasing Program, would drive measurable improvements in outcomes while advancing the goals of equitable, value-based care.

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[9] Saghafi-Asl, M., et al. (2021). *Malnutrition and hospital readmission: A systematic review and meta-analysis*. Clinical Nutrition ESPEN. https://doi.org/10.1016/j.clnesp.2021.01.003

[10] Ngandu, T., et al. (2015). *A 2-year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER)*. The Lancet. https://doi.org/10.1016/S0140-6736(15)60461-5

[11] Centers for Medicare & Medicaid Services (CMS). (2021). *Chronic Care Management Report to Congress*. https://www.cms.gov

[12] Sherrington, C., et al. (2020). *Exercise for preventing falls in older people living in the community*. British Journal of Sports Medicine. https://doi.org/10.1136/bjsports-2019-101512

[13] Institute for Healthcare Improvement. (2020). *Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults*. https://www.ihi.org

We urge CMS to prioritize the integration of nutrition and overall well-being into future quality measure development, particularly as it relates to skilled nursing facilities (SNFs). Strengthening these areas can play a critical role in enhancing physical resilience, reducing avoidable rehospitalizations, and supporting long-term recovery—especially among vulnerable populations disproportionately impacted by poor nutrition and health disparities. At the same time, we recognize that additional measures can increase the administrative burden on providers. To ensure success and sustainability, these efforts should be implemented in a manner that minimizes burden and includes dedicated funding to support data collection and reporting. As noted above, this may include utilizing data elements that have already been adopted into the SNF QRP and for which SNFs have been preparing to collect and submit for almost a year. This presents a strategic opportunity to align with and potentially expand the Value-Based Purchasing (VBP) Program, allowing for meaningful, outcomes-driven improvements without adding undue strain on the system.

Credentialing Barriers with Medicare Advantage Organizations

NARA continues to hear significant concerns from our members regarding restricted provider networks and excessively lengthy credentialing and contracting processes with commercial payers offering MA plans. These processes can take between 90 to 180 days, during which time beneficiaries may face substantial barriers to accessing timely care—particularly those in HMO plans, with limited transportation options, or residing in assisted and independent living communities where the provider on-site is not yet credentialed.

A key issue compounding this delay is the lack of retroactive contract effective dates. Unlike traditional Medicare, where private practice providers can often receive a retroactive enrollment date within established CMS parameters, MA plans frequently delay contract activation without retroactivity—effectively preventing beneficiaries from receiving needed care for months after referral by their physician. This is not just an administrative inconvenience; it is a care access issue that disproportionately affects medically complex and mobility-limited beneficiaries, in direct conflict with CMS's goals of reducing avoidable care delays and easing provider burden. Moreover, these delays are paired with lower reimbursement rates and higher administrative demands, making it increasingly unsustainable for providers to participate in MA networks.

NARA urges CMS to:

- Standardize and streamline credentialing and contracting processes across MAs, mirroring the timeliness and retroactivity standards already established for traditional Medicare;
- Mandate retroactive effective dates for credentialed Medicare providers upon completion of the application, where appropriate;
- Increase oversight and transparency of MA network management practices, ensuring they align with CMS's goals of timely access to care; and
- Monitor and mitigate administrative burdens that detract from clinical care delivery, especially in underserved or aging communities.

As MA enrollment continues to grow rapidly due to added benefits and cost flexibility, CMS must ensure that provider networks and administrative processes keep pace — protecting both beneficiary access and provider participation in the program.

Conclusion

Our members continue to face significant challenges in maintaining operations and delivering high-quality care amidst ongoing reimbursement reductions and increased regulatory penalties. Providers are working tirelessly to protect the well-being of their patients and staff, yet report that excessive administrative requirements divert critical clinical resources and time away from direct patient care. Many tasks mandated by current regulations do not align with staff skillsets, contributing to inefficiencies, burnout, and ultimately jeopardizing patient access to essential services.

NARA thanks CMS for the opportunity to provide feedback on this proposed rule and for your continued engagement with stakeholders. We also look forward to submitting comments on Executive Order 14192, *Unleashing Prosperity Through Deregulation of the Medicare Program*. As the healthcare workforce shortage intensifies, CMS's efforts to reduce provider burden and streamline regulatory processes are more important than ever. We urge CMS to continue prioritizing policies that support provider sustainability and ensure timely, equitable access to care for all Medicare beneficiaries.

Thank you again for the opportunity to provide input. Should you have any questions regarding our comments, please contact Christie Covington, NARA Executive Director, at christie.covington@naranet.org.

Respectfully submitted,

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