LONG TERM CARE
COMMUNITY COALITION

Advancing Quality, Dignity & Justice

May 13, 2026

Centers for Medicare & Medicaid Services
Submitted electronically via 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 2027; Proposed Rule, CMS-1843-P

Dear Administrator Oz:

The Long Term Care Community Coalition (LTCCC) appreciates the opportunity to comment on CMS's proposed FY 2027 Skilled Nursing Facility (SNF) Prospective Payment System (PPS), Quality Reporting Program (QRP), and Value-Based Purchasing (VBP) updates. LTCCC is a nonprofit, non-partisan organization dedicated to improving care, quality of life, and dignity for nursing home residents and other older adults and people with disabilities who receive long-term care.

We focus our comments on four issues: financial accountability for Medicare payments; the need to rely on accurate, independently verifiable quality data; preservation and strengthening of infection-prevention transparency; and adoption of concrete staffing and professional-service measures. Our recommendations are grounded in longstanding federal minimum standards, independent federal oversight reports, peer-reviewed research, and our own studies of federal nursing home oversight, quality, and staffing data.

I. CMS should strengthen financial accountability before increasing SNF payments.

CMS proposes to update FY 2027 SNF PPS rates while also seeking input on case-mix creep under PDPM and continuing to rely on cost-report data that federal oversight bodies have repeatedly found to be insufficiently transparent or reliable.[1] We urge CMS to condition payment policy on stronger safeguards to reduce fraud, waste, and abuse and better ensure that Medicare dollars are used for resident care.

MedPAC's March 2026 report once again recommended that Congress reduce 2026 Medicare base payment rates for SNFs by four percent in FY 2027. MedPAC found, once again, that indicators of payment adequacy were largely positive; Medicare FFS payments per day to freestanding SNFs increased faster than costs per day from 2023 to 2024 and the FFS Medicare margin for freestanding

[1] Centers for Medicare & Medicaid Services, "Fiscal Year (FY) 2027 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS 1843-P)," April 2, 2026, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2027-skilled-nursing-facility-prospective-payment-system-proposed-rule-cms-1843-p.

SNFs was 24 percent in 2024, up from 22 percent in 2023.[2] MedPAC also noted that nursing homes have reaped double-digit profits every year for the last 25 years.

Despite sustained profitability and regular increases in Medicare reimbursement, the nursing home industry continues to be marked by pervasive and persistent quality, staffing, and oversight failures. Federal data and independent oversight reports continue to document widespread understaffing, high staff turnover, serious deficiencies, infection-control failures, inappropriate antipsychotic drugging, and failures to prevent avoidable harm to residents. LTCCC's analyses of CMS staffing and survey data have consistently found that a large proportion of facilities fail to provide sufficient registered nurse and total nursing staff hours to meet resident needs and federal minimum care standards.[3] Meanwhile, the industry has become increasingly corporatized and financially complex, with growing use of private equity and real estate investment trust ownership arrangements, related-party transactions, and management arrangements that obscure profits and divert resources away from resident care.[4] Federal enforcement actions and OIG investigations have also continued to identify fraud, inaccurate reporting, and misuse of Medicare and Medicaid funds.[5]

These persistent quality and oversight failures — together with longstanding GAO and OIG findings regarding inaccurate reporting, undisclosed related-party transactions, weak Medicare oversight, and vulnerabilities to fraud, waste, and abuse — underscore the need for substantially stronger financial accountability, transparency, and program integrity safeguards before additional Medicare payment increases are adopted.

LTCCC therefore recommends that CMS:

1. Implement a direct-care spending standard for Medicare SNF payments of at least 85%, limiting the share of public reimbursement that may be diverted to administration, capital, and profits rather than resident care to no more than 15%.
2. Require independently audited SNF cost reports before those reports are used in rate-setting or wage-index policy.
3. Require MAC review of related-party disclosures and related-party costs as a routine part of desk reviews and audits.
4. Establish clear, enforceable penalties for inaccurate or incomplete financial, ownership, and related-party reporting.

These recommendations are consistent with the public interest in reducing fraud and waste and improving care for vulnerable nursing home residents.

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[2] Medicare Payment Advisory Commission, "Chapter 7: Skilled Nursing Facility Services," in *Report to the Congress: Medicare Payment Policy*, March 2026, pp. 215-19, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch7_MedPAC_Report_To_Congress_SEC.pdf.

[3] *See*, for example, "Over 1 Million Vulnerable Residents in Understaffed US Nursing Homes," March 5, 2026. https://nursinghome411.org/alert-staffing-q3-2025/

[4] Jordan Rau, "Care Suffers as More Nursing Homes Feed Money Into Corporate Webs," *The New York Times*, Jan. 2, 2018, https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html.

[5] U.S. Department of Health and Human Services, Office of Inspector General, *Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs*, A-07-21-02836, Dec. 18, 2024, https://oig.hhs.gov/reports/all/2024/some-selected-skilled-nursing-facilities-did-not-comply-with-medicare-requirements-for-reporting-related-party-costs/.

II. CMS should reduce reliance on self-reported MDS quality measures and use claims-based, audited, and structural data wherever possible.

LTCCC strongly supports quality reporting. But reporting is only useful when the underlying data are accurate. CMS should not continue expanding or relying on measures that create financial or reputational incentives for facilities to underreport adverse events or otherwise manipulate self-reported data.

The evidence of this problem is substantial. In 2025, OIG found that nursing homes failed to report 43 percent of falls with major injury and hospitalization among Medicare-enrolled residents on MDS assessments. OIG further found that this failure resulted in inaccurate fall rates on Care Compare and that facilities with the lowest Care Compare fall rates were least likely to report the falls OIG examined.[6] A 2023 JAMA Network Open study similarly found widespread underreporting in nursing home quality measures: only 60 percent of major-injury fall hospitalizations and 67.7 percent of stage 3 or 4 pressure ulcer hospitalizations were reported in MDS data.[7]

The same concerns apply to antipsychotic drug reporting. OIG has found that the nursing home antipsychotic quality measure creates incentives to inappropriately diagnose residents with schizophrenia because residents with that diagnosis are excluded from the measure. OIG's 2026 review found instances in which nursing homes inappropriately diagnosed residents with schizophrenia to mask misuse of antipsychotic drugs, artificially inflate star ratings, and avoid safeguards meant to protect residents.[8]

LTCCC's own research has similarly documented longstanding concerns regarding the inappropriate use of antipsychotic medications in nursing homes and the inadequacy of federal oversight. In a 2022 review of more than a decade of federal initiatives to reduce unnecessary antipsychotic drugging, LTCCC found that although reported antipsychotic use declined nationally, substantial evidence indicated that too many facilities responded by increasing schizophrenia diagnoses, which resulted in suppression of their true drugging rates in CMS data, rather than meaningfully reducing inappropriate prescribing. The report also highlighted persistent racial disparities, ongoing use of antipsychotics as chemical restraints for residents with dementia, and continuing risks of serious harm, including falls, strokes, hospitalization, and death. These findings underscore the importance of strengthening — not weakening — oversight and public reporting related to antipsychotic use in nursing homes.[9]

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[6] U.S. Department of Health and Human Services, Office of Inspector General, *Nursing Homes Failed To Report 43 Percent of Falls With Major Injury and Hospitalization Among Their Medicare-Enrolled Residents*, OEI-05-24-00180, Sept. 11, 2025, https://oig.hhs.gov/reports/all/2025/nursing-homes-failed-to-report-43-percent-of-falls-with-major-injury-and-hospitalization-among-their-medicare-enrolled-residents/.

[7] Prachi Sanghavi and Zihan Chen, "Underreporting of Quality Measures and Associated Facility Characteristics and Racial Disparities in U.S. Nursing Home Ratings," *JAMA Network Open* 6, no. 5 (2023): e2314822, doi:10.1001/jamanetworkopen.2023.14822.

[8] U.S. Department of Health and Human Services, Office of Inspector General, *Nursing Homes Inappropriately Diagnosed Residents with Schizophrenia to Mask the Misuse of Antipsychotic Drugs*, OEI-02-23-00201, March 2026, https://oig.hhs.gov/reports/all/2026/nursing-homes-inappropriately-diagnosed-residents-with-schizophrenia-to-mask-the-misuse-of-antipsychotic-drugs/.

[9] LTCCC, *A Decade of Drugging: Federal Inaction and Continued Misuse of Antipsychotic Drugs in Nursing Homes* (Dec. 2022), https://nursinghome411.org/wp-content/uploads/2022/12/Decade-Drugging-LTCCC-122022.pdf. The report documents evidence of ongoing inappropriate antipsychotic drug use, increases in schizophrenia diagnoses potentially linked to quality measure exclusions, persistent racial disparities, and continuing risks of serious harm to nursing home residents.

CMS should therefore adopt the following principles in SNF QRP and VBP policy:

1. Base SNF QRP and VBP measures primarily on claims-based and other independently verifiable data sources whenever available.
2. Phase out self-reported MDS measures for outcomes such as falls, pressure injuries, and antipsychotic use unless CMS implements credible auditing and meaningful penalties for inaccurate reporting.
3. Continue to use PBJ staffing data and other auditable structural measures, while strengthening CMS review of those data and imposing penalties for false or inaccurate reporting.
4. Require Medicare Advantage organizations and other payers to provide encounter or claims data sufficient to monitor quality and access for all SNF residents, including residents whose care is not reflected in FFS claims.

LTCCC strongly supports CMS's proposal to require MDS submission for all SNF residents regardless of payer source, but believes implementation should occur far sooner than FY 2031. Facilities already conduct MDS assessments for residents as part of existing care and assessment requirements, so submission of those data should impose minimal additional burden. Full-resident reporting is increasingly important as Medicare Advantage enrollment grows because accurate assessment of resident acuity, staffing needs, and quality outcomes depends upon complete facility-wide data rather than fee-for-service Medicare data alone.

III. CMS should retain COVID-19 vaccination reporting for residents and health care personnel and strengthen infection-prevention transparency.

LTCCC opposes removing the COVID-19 vaccination coverage measures for health care personnel and residents from the SNF QRP. CMS's own fact sheet states that the proposed rule would remove both the health care personnel COVID-19 vaccination measure and the resident up-to-date COVID-19 vaccination measure beginning with the FY 2028 SNF QRP.[10]

Nursing home residents remain uniquely vulnerable to respiratory infections because of age, disability, comorbidities, congregate living, and frequent close contact with staff. Residents, families, discharge planners, ombudsmen, and regulators need current facility-level information on vaccination coverage to assess preventable risk.

IV. CMS should strengthen the SNF VBP program by relying on accurate, auditable, and clinically meaningful measures.

LTCCC supports the use of quality measures in the SNF VBP program when those measures are based on reliable data and meaningfully reflect resident care and outcomes. We support the current VBP measures for health care-associated infections requiring hospitalization, total nurse staffing hours per resident day, and nursing staff turnover. Staffing levels and staff stability are strongly associated with

[10] Centers for Medicare & Medicaid Services, "Fiscal Year (FY) 2027 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS 1843-P)," April 2, 2026.

resident safety and quality of care and are among the most concrete and auditable indicators currently available to CMS.

At the same time, CMS should exercise caution in adopting or expanding measures that may create unintended incentives that could undermine resident welfare and the appropriate use of taxpayer funds. For instance, measures such as 30-day all-cause readmissions and hospitalizations per 1,000 long-stay resident days may identify potentially avoidable hospital use, but they may also create incentives for facilities and Medicare Advantage plans to avoid appropriate hospitalization or transfer when residents require a higher level of care. This concern is especially significant in light of growing Medicare Advantage enrollment and longstanding concerns regarding plan incentives to limit post-acute and inpatient utilization. Quality measures should not encourage facilities to retain residents whose clinical needs exceed the facility's capabilities.

As discussed above, LTCCC is particularly concerned about the continued reliance on self-reported MDS data in both QRP and VBP programs. Numerous federal oversight reports and peer-reviewed studies have found substantial underreporting of falls, pressure injuries, and other adverse outcomes in MDS-based quality measures. Facilities have strong financial and reputational incentives to manipulate self-reported quality data, especially when those measures are directly tied to public ratings or payment incentives. CMS should therefore prioritize claims-based and other independently verifiable measures whenever possible and should not continue to expand payment incentives tied to unaudited self-reported data.

LTCCC therefore recommends that CMS:

1. Continue and strengthen VBP measures based on concrete, auditable indicators, including health care-associated infections requiring hospitalization, total nurse staffing hours per resident day, and nursing staff turnover.
2. Exercise caution in the use of readmission and hospitalization measures to ensure that facilities and Medicare Advantage plans are not incentivized to avoid medically necessary hospital transfers or retain residents whose clinical needs exceed facility capabilities.
3. Prioritize claims-based and other independently verifiable measures over self-reported MDS measures whenever possible and phase out reliance on self-reported measures unless CMS implements credible auditing systems and meaningful penalties for inaccurate reporting.
4. Expand the use of auditable structural measures within VBP, including RN, LPN/LVN, CNA, and total nursing staffing levels; staff turnover; weekend staffing; and paid hours for medical directors, pharmacists, social workers, dietitians, therapists, and activities staff.
5. Evaluate staffing and professional-service measures in relation to resident acuity and case mix. A 2025 peer-reviewed staffing guide co-authored by LTCCC's executive director demonstrates that expected staffing levels can and should be assessed based upon resident case mix and care needs rather than industry averages alone.[11]
6. Audit PBJ and other provider-reported data regularly and impose meaningful penalties for false, inaccurate, or incomplete reporting used in public reporting or payment programs.

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[11] Charlene A. Harrington et al., "Nursing Home Guide to Adjusting Nurse Staffing for Resident Case-Mix," *Journal of the American Geriatrics Society* 73, no. 7 (2025): 2137-45, doi:10.1111/jgs.19501.

7. Require Medicare Advantage organizations and other payers to provide encounter or claims data sufficient to monitor quality, utilization, and access for all SNF residents, including residents whose care is not reflected in fee-for-service Medicare claims.
8. Require MDS submission for all SNF residents regardless of payer source substantially sooner than FY 2031. Facilities already complete MDS assessments as part of existing resident assessment obligations, and comprehensive reporting is necessary to ensure accurate assessment of resident acuity, staffing needs, quality outcomes, and facility performance across the entire resident population.

These data should be audited and used for enforcement, not merely public reporting and VBP. LTCCC's nursing home oversight study found that persistent poor care reflects failures at the facility, state, and federal levels; improving quality therefore requires not only improvement in the measures used, but reliable data, stronger oversight, and meaningful consequences for noncompliance.[12]

V. LTCCC supports CMS action on case-mix creep, but adjustment factors alone are not enough.

LTCCC supports CMS's request for information regarding methodology for quantifying and addressing case-mix creep under PDPM. We agree that payment systems relying heavily on provider-reported assessment data create significant incentives for coding practices that increase reimbursement without necessarily reflecting corresponding increases in resident care needs. Strengthening oversight of PDPM coding and assessment accuracy is also consistent with CMS's stated priority of reducing fraud, waste, abuse, and misuse of taxpayer funds within Medicare payment systems.

In this regard, LTCCC strongly supports the recommendations submitted by the Geriatric Circle regarding stronger oversight of assessment accuracy, improved accountability for provider-reported data, and reforms to reduce incentives for inappropriate upcoding and manipulation of PDPM classifications.

Conclusion

Nursing home residents and their families depend upon Medicare and Medicaid to ensure that nursing facilities provide safe, competent, and dignified care consistent with longstanding federal standards. Yet, despite decades of strong industry profitability and repeated increases in public reimbursement, serious problems in staffing, quality, transparency, and oversight remain widespread and persistent. Too often, residents and families continue to experience preventable harm, inadequate staffing, inaccurate reporting, and systems that reward appearances of quality rather than accountability and resident outcomes.

CMS therefore has an important opportunity in this rulemaking to strengthen both resident protections and program integrity. The recommendations discussed above would help ensure that Medicare payments are directed toward resident care rather than excessive administrative costs, undisclosed related-party arrangements, or other uses that do not improve resident well-being. They would also strengthen the reliability of publicly reported quality information, improve accountability

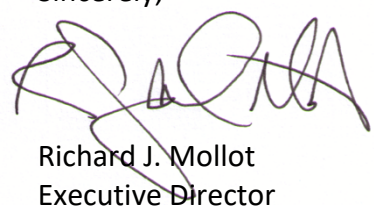
[12] LTCCC, "Broken Promises."

for provider-reported data, and support more meaningful oversight of staffing, therapy, infection prevention, and resident outcomes.

These reforms are consistent with CMS's stated commitment to reducing fraud, waste, abuse, and misuse of taxpayer funds. Stronger financial transparency, audited reporting, accurate quality measurement, and meaningful enforcement are essential safeguards for both residents and the Medicare program itself. American families count on nursing homes to provide appropriate care for some of the nation's most vulnerable individuals. CMS should use this rulemaking to help ensure that those promises are met through stronger accountability, greater transparency, and policies that prioritize resident care and safety.

Thank you for considering these comments.

Sincerely,



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