DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1843–P]

RIN 0938–AV75

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This rule proposes changes and updates to the policies and payment rates used under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for fiscal year 2027. This proposed rule also updates the requirements for the SNF Quality Reporting Program and the SNF Value-Based Purchasing Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by June 1, 2026.

ADDRESSES: In commenting, please refer to file code CMS–1843–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address *only:*

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1843–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address *only:*

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1843–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

PDPM@cms.hhs.gov for issues related to the SNF PPS.

Heidi Magladry, (410) 786–6034, for information related to the Skilled Nursing Facility Quality Reporting Program.

Christopher Palmer, (410) 786–8025, for information related to the Skilled Nursing Facility Value-based Purchasing Program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov/.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

As discussed in the FY 2014 SNF PPS final rule (78 FR 47936), tables setting forth the Wage Index for Urban Areas Based on Core Based Statistical Area (CBSA) Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas are no longer published in the **Federal Register**. Instead, these tables are available exclusively through the internet on the CMS website. The wage index tables for this proposed rule can be accessed on the SNF PPS Wage Index home page, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

Readers who experience any problems accessing any of these online SNF PPS wage index tables should contact Patricia Taft at (410) 786–4561.

I. Executive Summary

A. Purpose

This proposed rule would update the skilled nursing facility (SNF) prospective payment rates for fiscal year (FY) 2027, as required under section 1888(e)(4)(E) of the Social Security Act (the Act). It would also implement section 1888(e)(4)(H) of the Act, which requires the Secretary to publish specified information relating to the payment update (see section II.C. of this proposed rule) in the **Federal Register** before the August 1 that precedes the start of each fiscal year. We are also proposing to continue to use the concurrent pre-floor, pre-reclassified Inpatient Prospective Payment System (IPPS) hospital wage index as the basis for the SNF wage index. In this proposed rule, we are not proposing any substantive changes to the Patient Driven Payment Model (PDPM) ICD–10 code mappings. This proposed rule proposes updates to the SNF Quality Reporting Program (QRP) including removing two measures from the program, specifically the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure and the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure. We are also proposing the revision of the SNF QRP data submission deadlines. In addition, we are proposing to require the submission of MDS data on each resident receiving covered skilled care in a SNF, regardless of payer. Finally, we are requesting comment on future measure concepts for the SNF QRP. We are also proposing updates to the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, including estimating performance standards and updating the review and correction policy for measures calculated with MDS assessment data. This proposed rule also includes a Request for Information (RFI) on the methodology for quantifying and addressing case-mix creep under PDPM.

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and (e)(5) of the Act, this proposed rule would update the annual rates that we published in the SNF PPS final rule for FY 2026 (90 FR 37310).

For the SNF QRP we are proposing to remove two measures beginning with the FY 2028 SNF QRP: the COVID–19 Vaccination Coverage Among Healthcare Personnel Measure and the COVID–19 Vaccine: Percent of Patients/Residents Who are Up to Date Measure. Additionally, we are proposing revisions to the data submission deadlines for data collected for the SNF QRP from 4.5 months after the end of each quarter to the 15th day of the second month after the end of the

quarter beginning with the FY 2029 SNF QRP. We are also proposing to require the submission of MDS data on all SNF residents admitted for covered skilled care regardless of payer beginning with the FY 2031 SNF QRP. Finally, we are requesting comment on future measure concepts for the SNF QRP.

For the SNF VBP Program, we are providing estimated performance standards for the FY 2029 and FY 2030 program years to comply with the Program's statutory notice deadline. We are also proposing to update the ''snapshot date'' codified at 42 CFR 413.338(f)(1)(v) for two measures that are calculated using MDS assessment data to maintain alignment with proposed SNF QRP submission deadlines for MDS assessment data, beginning with FY 2027 data.

C. Summary of Cost and Benefits

TABLE 1—ESTIMATED COST AND BENEFITS

Updates	Estimated total transfers/costs
FY 2027 SNF PPS payment rate update	The overall economic impact of this proposed rule is an estimated increase of $888 million in aggregate payments to SNFs during FY 2027.
FY 2028 SNF QRP changes due to the removal of two measures.	The overall economic impact of this proposed rule to SNFs is an estimated decrease of $8.3 million annually to SNFs beginning with the FY 2028 SNF QRP.
FY 2031 SNF QRP changes due to the requirement to submit MDS data on each resident receiving skilled care regardless of payer.	The overall economic impact of this proposed rule to those SNFs is an estimated increase of $88 million annually to SNFs beginning with the FY 2031 SNF QRP.
FY 2027 SNF VBP changes	The overall economic impact of the SNF VBP Program is an estimated reduction of $203.41 million in aggregate payments to SNFs during FY 2027.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA 1997) (Pub. L. 10533, enacted August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for SNFs. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers virtually all costs of furnishing covered SNF services (routine, ancillary, and capital related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Medicare Part A, as well as those items and services (other than a small number of excluded services, such as physicians' services) for which payment may otherwise be made under Medicare Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Medicare Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998, interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_2018-10-01.pdf.*

Section 215(a) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93, enacted April 1, 2014) added new section 1888(g) to the Act, requiring the Secretary to specify an all-cause all-condition hospital readmission measure and an all-condition risk-adjusted potentially preventable hospital readmission measure for the SNF setting. Additionally, section 215(b) of PAMA added section 1888(h) to the Act requiring the Secretary to implement a VBP program for SNFs. In 2014, section 2(c)(4) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (Pub. L. 113–185, enacted October 6, 2014) amended section 1888(e)(6) of the Act, which requires the Secretary to implement a QRP for SNFs under which SNFs report data on measures and resident assessment data. Finally, section 111 of the Consolidated Appropriations Act, 2021 (CAA, 2021) (Pub. L. 116–260, enacted December 27, 2020) amended section 1888(h)(2)(A) of the Act, authorizing the Secretary to apply up to ten measures to the VBP program for SNFs.

B. Initial Transition for the SNF PPS

Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The transition extended through the facility's first 3 cost reporting periods under the prospective payment system, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments for SNFs entirely on the adjusted Federal per diem rates, we no longer include adjustment factors under the transition related to facility-specific rates for the upcoming FY.

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in a final rule that set forth updates to the SNF PPS payment rates for FY 2026 (90 FR 37310).

Section 1888(e)(4)(H) of the Act specifies that we provide for publication annually in the **Federal Register** the following:

- The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
- The case-mix classification system to be applied for these services during the upcoming FY.
- The factors to be applied in making the area wage adjustment for these services.

Along with other revisions discussed in this preamble, this proposed rule will set out the required annual updates to the per diem payment rates for SNFs for FY 2027.

III. Proposed SNF PPS Ratesetting Methodology and FY 2027 Payment Update

A. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem Federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods

beginning in FY 1995. The data used in developing the Federal rates also incorporated a Medicare Part B add-on, which is an estimate of the amounts that, prior to the SNF PPS, would be payable under Medicare Part B for covered SNF services furnished to individuals during a covered Medicare Part A stay in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of the PPS (the 15-month period beginning July 1, 1998) using the SNF market basket and then standardized for geographic variations in wages and for the costs of facility differences in case mix. In compiling the database used to compute the Federal payment rates, we excluded those providers that received new provider exemptions from the routine cost limits, as well as costs related to payments for exceptions to the routine cost limits. Using the formula that the BBA 1997 prescribed, we set the Federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We computed and applied separately the payment rates for facilities located in urban and rural areas and adjusted the portion of the Federal rate attributable to wage related costs by a wage index to reflect geographic variations in wages.

B. SNF Market Basket Update

1. SNF Market Basket

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, we have developed a SNF market basket that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the SNF PPS final rule for FY 2025 (89 FR 64065 through 64082), we rebased and revised the SNF market basket, which included updating the base year from 2018 to 2022.

The SNF market basket is used to compute the market basket percentage increase that is used to update the SNF Federal rates on an annual basis, as required by section 1888(e)(4)(E)(ii)(IV) of the Act. This market basket percentage increase is adjusted by a forecast error adjustment, if applicable, and then further adjusted by the application of a productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act and described in section III.B.4. of this proposed rule.

As outlined in this proposed rule, we are proposing a FY 2027 SNF market basket percentage increase of 3.2 percent based on IHS Global Inc.'s (IGI's) fourth-quarter 2025 forecast of the 2022-based SNF market basket (before application of the forecast error adjustment and productivity adjustment). We are also proposing that if more recent data subsequently become available (for example, a more recent estimate of the market basket, the productivity adjustment, or the forecast error adjustment), we would use such data, if appropriate, to determine the FY 2027 SNF market basket percentage increase, labor-related share relative importance, forecast error adjustment, or productivity adjustment in the SNF PPS final rule.

2. Market Basket Update Factor for FY 2027

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage increase as the percentage change in the SNF market basket from the midpoint of the previous FY to the midpoint of the current FY. For the Federal rates outlined in this proposed rule, we use the percentage change in the SNF market basket to compute the update factor for FY 2027. This factor is based on the FY 2027 percentage increase in the 2022-based SNF market basket reflecting routine, ancillary, and capital -related expenses. Sections 1888(e)(4)(E)(ii)(IV) and (e)(5)(B)(i) of the Act require that the update factor used to establish the FY 2027 unadjusted Federal rates be at a level equal to the SNF market basket percentage increase. Accordingly, we determined the total growth from the average market basket level for the period of October 1, 2025, through September 30, 2026, to the average market basket level for the period of October 1, 2026, through September 30, 2027. This process yields a percentage increase in the 2022-based SNF market basket of 3.2 percent for FY 2027.

As further explained in section IV.B.3. of this proposed rule, as applicable, we propose to adjust the percentage increase by the forecast error adjustment from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage increase in the market basket exceeds a 0.5 percentage point threshold in absolute terms. Additionally, section 1888(e)(5)(B)(ii) of the Act requires us to reduce the market basket percentage increase by the productivity adjustment (the 10 year moving average of changes in annual economy-wide private nonfarm business total multifactor productivity for the period ending September 30, 2027), which is estimated to be 0.8 percentage point, as described in section IV.B.4. of this proposed rule.

We also note that section 1888(e)(6)(A)(i) of the Act provides that, beginning with FY 2018, SNFs that fail to submit data, as applicable, in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for a FY will receive a 2.0 percentage point reduction to their market basket update for the FY involved, after application of section 1888(e)(5)(B)(ii) of the Act (the productivity adjustment) and section 1888(e)(5)(B)(iii) of the Act (the market basket increase). In addition, section 1888(e)(6)(A)(ii) of the Act states that application of the 2.0 percentage point reduction (after application of section 1888(e)(5)(B)(ii) and (iii) of the Act) may result in the market basket percentage change being less than zero for a FY and may result in payment rates for a FY being less than such payment rates for the preceding FY. Section 1888(e)(6)(A)(iii) of the Act further specifies that the 2.0 percentage point reduction is applied in a noncumulative manner, so that any reduction made under section 1888(e)(6)(A)(i) of the Act applies only to the FY involved, and that the reduction cannot be taken into account in computing the payment amount for a subsequent FY.

3. Forecast Error Adjustment

As discussed in the June 10, 2003, supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003, final rule (68 FR 46057 through 46059), § 413.337(d)(2) provides for an adjustment to account for SNF market basket forecast error. The initial adjustment for SNF market basket forecast error applied to the update of the FY 2003 rate for FY 2004 and considered the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent FYs. As we stated in the final rule for FY 2004 that first issued the market basket forecast error adjustment (68 FR 46058), the

adjustment will reflect both upward and downward adjustments, as appropriate.

For FY 2025 (the most recently available FY for which there is final data), the forecasted or estimated increase in the SNF market basket was 3.0 percent, and the actual increase for FY 2025 was 2.8 percent, resulting in the actual increase being 0.2 percentage point lower than the estimated increase. Accordingly, as the difference between the estimated and actual percentage increase in the market basket does not exceed the 0.5 percentage point threshold, under the policy previously described (comparing the forecasted and actual market basket percentage increase), the FY 2027 market basket percentage increase of 3.2 percent would not be adjusted to account for the forecast error correction.

Table 2 shows the forecasted and actual market basket percentage increases for FY 2025.

TABLE 2—DIFFERENCE BETWEEN THE ACTUAL AND FORECASTED SNF MARKET BASKET PERCENTAGE INCREASES FOR FY 2025

Index	Forecasted FY 2025 percentage increase *	Actual FY 2025 percentage increase **	FY 2025 difference
SNF	3.0	2.8	−0.2

* Published in **Federal Register**; based on second quarter 2024 IHS Global Inc. forecast (2022-based SNF market basket).
** Based on the fourth quarter 2025 IHS Global Inc. forecast (2022-based SNF market basket), with historical data through third quarter 2025.

4. Productivity Adjustment

Section 1888(e)(5)(B)(ii) of the Act, as added by section 3401(b) of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148, enacted March 23, 2010), requires that, in FY 2012 and in subsequent FYs, the market basket percentage under the SNF payment system (as described in section 1888(e)(5)(B)(i) of the Act) is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, in turn, defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary of the Department of Health and Human Services (Secretary) for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment'').

The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measure of productivity for the United States. The productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is published by BLS as private nonfarm business total factor productivity *((TFP) previously referred to as multifactor productivity).*[1] We refer readers to the BLS website at *www.bls.gov/productivity* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on CMS's website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.*

Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the productivity adjustment may result in the market basket percentage being less than zero for a FY and may result in payment rates under section 1888(e) of the Act being less than such payment rates for the preceding FY. Thus, if the application of the productivity adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) of the Act results in a productivity adjusted market basket percentage that is less than zero, then the annual update to the unadjusted Federal per diem rates under section 1888(e)(4)(E)(ii) of the Act would be negative, and such rates would decrease relative to the prior FY.

Based on the data available for the FY 2027 SNF PPS proposed rule, the proposed productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business TFP for the period ending September 30, 2027) is projected to be 0.8 percentage point.

Consistent with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2), and as outlined previously in section III.B.1. of this proposed rule, the market basket percentage increase for FY 2027 for the SNF PPS, based on IHS Global Inc.'s fourth quarter 2025 forecast of the SNF market basket percentage increase, is estimated to be 3.2 percent. As outlined earlier in this section, we are applying a proposed 0.8 percentage point productivity adjustment to the FY 2027 SNF market basket percentage increase. Therefore, the resulting proposed FY 2027 SNF market basket update is equal to 2.4 percent.

5. Unadjusted Federal per Diem Rates for FY 2027

As stated in the FY 2019 SNF PPS final rule (83 FR 39162), in FY 2020 we implemented a new case-mix classification system to classify SNF patients under the SNF PPS, the PDPM. As stated in section V.B.1. of that final rule (83 FR 39189), under PDPM, the unadjusted Federal per diem rates are divided into six components, five of which are case-mix adjusted components (physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillaries (NTA)), and one of which is a non-case-mix component, as existed under the previous Resource Utilization Groups, Version IV (RUG–IV) model. We propose to use the SNF market basket update, adjusted as outlined previously in sections III.B.1. through III.B.4. of this proposed rule, to adjust each per diem component of the Federal rates forward to reflect the change in the average prices for FY 2027 from the average prices for FY 2026. We also propose further adjusting the rates by a wage index budget neutrality factor outlined in section III.D. of this proposed rule.

Further, in the past, we used the revised Office of Management and Budget (OMB) delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634), with updates as reflected in OMB Bulletins Nos. 15–01 and 17–01 to identify a facility's urban or rural status for the purpose of determining which set of rate tables apply to the facility. As discussed in the FY 2021 SNF PPS proposed and final rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) to

[1] *https://www.bls.gov/productivity/notices/2021/mfp-to-tfp-term-change.htm.*

identify a facility's urban or rural status effective beginning with FY 2021. As discussed in the FY 2025 SNF PPS proposed and final rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*) to identify a facility's urban or rural status effective beginning with FY 2025.

Tables 3 and 4 reflect the unadjusted Federal rates for FY 2027, prior to adjustment for case-mix.

TABLE 3—FY 2027 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$77.45	$72.09	$28.92	$134.99	$101.85	$120.89

TABLE 4—FY 2027 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$88.29	$81.09	$36.44	$128.98	$97.31	$123.13

C. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the Federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. The previous RUG–IV model classified most patients into a therapy payment group and primarily used the volume of therapy services provided to the patient as the basis for payment classification, thus creating an incentive for SNFs to furnish therapy regardless of the individual patient's unique characteristics, goals, or needs. PDPM eliminates this incentive and improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing the administrative burden on SNFs.

The PDPM uses clinical data from the minimum data set (MDS), a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid, consistent with the provisions of section 1888(e)(4)(G)(i) of the Act. As outlined in section IV.A. of this proposed rule, the clinical orientation of the case-mix classification system supports the SNF PPS's use of an administrative presumption that considers a beneficiary's initial case-mix classification to assist in making certain SNF level of care determinations. Further, because the MDS is used as a basis for payment, as well as a clinical assessment, we have provided extensive training on proper coding and the timeframes for MDS completion in our Resident Assessment Instrument (RAI) Manual. As previously stated, for an MDS to be considered valid for use in determining payment, the MDS assessment must be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS website at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.*

Under section 1888(e)(4)(H) of the Act, each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The FY 2027 payment rates set forth in this proposed rule reflect the use of the PDPM case-mix classification system from October 1, 2026, through September 30, 2027. The case-mix adjusted PDPM payment rates for FY 2027 are listed separately for urban and rural SNFs, in Tables 5 and 6 with corresponding case-mix values.

Given the differences between the previous RUG–IV model and PDPM in terms of patient classification and billing, it was important that the format of Tables 5 and 6 reflect these differences. More specifically, under both RUG–IV and PDPM, providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim to bill for covered SNF services. Under RUG–IV, the HIPPS code included the three-character RUG–IV group into which the patient classified, as well as a two-character assessment indicator code that represented the assessment used to generate this code. Under PDPM, while providers still use a HIPPS code, the characters in that code represent different things. For example, the first character represents the PT and OT group into which the patient classifies. If the patient is classified into the PT and OT group ''TA'', then the first character in the patient's HIPPS code would be an ''A.'' Similarly, if the patient is classified into the SLP group ''SB'', then the second character in the patient's HIPPS code would be a ''B.'' The third character represents the Nursing group into which the patient classifies. The fourth character represents the NTA group into which the patient classifies. Finally, the fifth character represents the assessment used to generate the HIPPS code.

Tables 5 and 6 reflect the PDPM's structure. Accordingly, Column 1 of Tables 5 and 6 represents the character in the HIPPS code associated with a given PDPM component. Columns 2 and 3 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant PT group. Columns 4 and 5 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant OT group. Columns 6 and 7 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant SLP group. Column 8 provides the nursing case-mix group (CMG) connected with a given PDPM HIPPS character. For example, if the patient qualified for the nursing group CBC1, then the third character in the patient's HIPPS code would be a ''P.'' Columns 9 and 10 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant nursing group. Finally, columns 11 and 12 provide the case-mix index and associated case-mix adjusted component

rate, respectively, for the relevant NTA group.

Tables 5 and 6 do not reflect adjustments which may be made to the SNF PPS rates as a result of the SNF VBP Program, outlined in section VII. of this proposed rule, or other adjustments, such as the variable per diem adjustment.

TABLE 5—PDPM CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN

PDPM group	PT CMI	PT rate	OT CMI	OT rate	SLP CMI	SLP rate	Nursing CMG	Nursing CMI	Nursing rate	NTA CMI	NTA rate
A	1.45	$112.30	1.41	$101.65	0.64	$18.51	ES3	3.84	$518.36	3.06	$311.66
B	1.61	124.69	1.54	111.02	1.72	49.74	ES2	2.90	391.47	2.39	243.42
C	1.78	137.86	1.60	115.34	2.52	72.88	ES1	2.77	373.92	1.74	177.22
D	1.81	140.18	1.45	104.53	1.38	39.91	HDE2	2.27	306.43	1.26	128.33
E	1.34	103.78	1.33	95.88	2.21	63.91	HDE1	1.88	253.78	0.91	92.68
F	1.52	117.72	1.51	108.86	2.82	81.55	HBC2	2.12	286.18	0.68	69.26
G	1.58	122.37	1.55	111.74	1.93	55.82	HBC1	1.76	237.58	.....	.....
H	1.10	85.20	1.09	78.58	2.70	78.08	LDE2	1.97	265.93	.....	.....
I	1.07	82.87	1.12	80.74	3.34	96.59	LDE1	1.64	221.38	.....	.....
J	1.34	103.78	1.37	98.76	2.83	81.84	LBC2	1.63	220.03	.....	.....
K	1.44	111.53	1.46	105.25	3.50	101.22	LBC1	1.35	182.24	.....	.....
L	1.03	79.77	1.05	75.69	3.98	115.10	CDE2	1.77	238.93	.....	.....
M	1.20	92.94	1.23	88.67	.....	.....	CDE1	1.53	206.53	.....	.....
N	1.40	108.43	1.42	102.37	.....	.....	CBC2	1.47	198.44	.....	.....
O	1.47	113.85	1.47	105.97	.....	.....	CA2	1.03	139.04	.....	.....
P	1.02	79.00	1.03	74.25	.....	.....	CBC1	1.27	171.44	.....	.....
Q	.....	.....	.....	.....	.....	.....	CA1	0.89	120.14	.....	.....
R	.....	.....	.....	.....	.....	.....	BAB2	0.98	132.29	.....	.....
S	.....	.....	.....	.....	.....	.....	BAB1	0.94	126.89	.....	.....
T	.....	.....	.....	.....	.....	.....	PDE2	1.48	199.79	.....	.....
U	.....	.....	.....	.....	.....	.....	PDE1	1.39	187.64	.....	.....
V	.....	.....	.....	.....	.....	.....	PBC2	1.15	155.24	.....	.....
W	.....	.....	.....	.....	.....	.....	PA2	0.67	90.44	.....	.....
X	.....	.....	.....	.....	.....	.....	PBC1	1.07	144.44	.....	.....
Y	.....	.....	.....	.....	.....	.....	PA1	0.62	83.69	.....	.....

TABLE B5—PDPM CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL

PDPM group	PT CMI	PT rate	OT CMI	OT rate	SLP CMI	SLP rate	Nursing CMG	Nursing CMI	Nursing rate	NTA CMI	NTA rate
A	1.45	$128.02	1.41	$114.34	0.64	$23.32	ES3	3.84	$495.28	3.06	$297.77
B	1.61	142.15	1.54	124.88	1.72	62.68	ES2	2.90	374.04	2.39	232.57
C	1.78	157.16	1.60	129.74	2.52	91.83	ES1	2.77	357.27	1.74	169.32
D	1.81	159.80	1.45	117.58	1.38	50.29	HDE2	2.27	292.78	1.26	122.61
E	1.34	118.31	1.33	107.85	2.21	80.53	HDE1	1.88	242.48	0.91	88.55
F	1.52	134.20	1.51	122.45	2.82	102.76	HBC2	2.12	273.44	0.68	66.17
G	1.58	139.50	1.55	125.69	1.93	70.33	HBC1	1.76	227.00	.....	.....
H	1.10	97.12	1.09	88.39	2.70	98.39	LDE2	1.97	254.09	.....	.....
I	1.07	94.47	1.12	90.82	3.34	121.71	LDE1	1.64	211.53	.....	.....
J	1.34	118.31	1.37	111.09	2.83	103.13	LBC2	1.63	210.24	.....	.....
K	1.44	127.14	1.46	118.39	3.50	127.54	LBC1	1.35	174.12	.....	.....
L	1.03	90.94	1.05	85.14	3.98	145.03	CDE2	1.77	228.29	.....	.....
M	1.20	105.95	1.23	99.74	.....	.....	CDE1	1.53	197.34	.....	.....
N	1.40	123.61	1.42	115.15	.....	.....	CBC2	1.47	189.60	.....	.....
O	1.47	129.79	1.47	119.20	.....	.....	CA2	1.03	132.85	.....	.....
P	1.02	90.06	1.03	83.52	.....	.....	CBC1	1.27	163.80	.....	.....
Q	.....	.....	.....	.....	.....	.....	CA1	0.89	114.79	.....	.....
R	.....	.....	.....	.....	.....	.....	BAB2	0.98	126.40	.....	.....
S	.....	.....	.....	.....	.....	.....	BAB1	0.94	121.24	.....	.....
T	.....	.....	.....	.....	.....	.....	PDE2	1.48	190.89	.....	.....
U	.....	.....	.....	.....	.....	.....	PDE1	1.39	179.28	.....	.....
V	.....	.....	.....	.....	.....	.....	PBC2	1.15	148.33	.....	.....
W	.....	.....	.....	.....	.....	.....	PA2	0.67	86.42	.....	.....
X	.....	.....	.....	.....	.....	.....	PBC1	1.07	138.01	.....	.....
Y	.....	.....	.....	.....	.....	.....	PA1	0.62	79.97	.....	.....

D. Wage Index Adjustment

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal payment rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. We will continue this practice for FY 2027, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data under the acute care hospital inpatient prospective payment system (IPPS) also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. As in previous years, we proposed to continue to use the pre-reclassified IPPS

hospital wage data, without applying the occupational mix, rural floor, or outmigration adjustment, as the basis for the SNF PPS wage index. For FY 2027, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2022, and before October 1, 2023 (FY 2023 cost report data).

Section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted December 21, 2000) gave the Secretary the discretion to establish a geographic reclassification procedure specific to SNFs, but only after collecting the data necessary to establish a SNF PPS wage index that is based on wage data from nursing homes. To date, this has proven to be unfeasible, due to the volatility of existing SNF wage data and the significant resources that would be required to improve the quality of the data. More specifically, 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. While we do not believe this undertaking is feasible at this time, we will continue to explore implementation of a spot audit process to improve SNF cost reports to ensure they are adequately accurate for cost development purposes, in such a manner as to permit us to establish a SNF-specific wage index in the future. We will continue to monitor the appropriateness of using the hospital data as a proxy and adjust in future rulemaking if we identify a better approach to the wage index.

In addition, we continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2027 SNF PPS wage index. For rural geographic areas that do not have hospitals and therefore lack hospital wage data on which to base an area wage adjustment, we will continue using the average wage index from all contiguous CBSAs as a reasonable proxy. For FY 2027, the only rural area without wage index data available is North Dakota. For urban areas without specific hospital wage index data, we will continue using the average wage indexes of all urban areas within the state to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2027, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. In adopting the CBSA geographic designations, we provided for a 1-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), after the expiration of this 1-year transition on September 30, 2006, we used the full CBSA-based wage index values.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010, **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provided minor updates to and superseded OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provided detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012, and July 1, 2013, and were adopted under the SNF PPS in the FY 2017 SNF PPS final rule (81 FR 51983, August 5, 2016). In addition, on August 15, 2017, OMB issued Bulletin No. 17–01 which announced a new urban CBSA, Twin Falls, Idaho (CBSA 46300), which was adopted in the SNF PPS final rule for FY 2019 (83 FR 39173, August 8, 2018).

As stated in the FY 2021 SNF PPS final rule (85 FR 47594), we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) beginning October 1, 2020, including a 1-year transition for FY 2021 under which we applied a 5 percent cap on any decrease in a hospital's wage index compared to its wage index for the prior FY 2020. The updated OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and the use of such delineations allows us to determine more accurately the appropriate wage index and rate tables to apply under the SNF PPS.

In the FY 2023 SNF PPS final rule (87 FR 47521 through 47525), we finalized a policy to apply a permanent 5 percent cap on any decreases to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. We amended the SNF PPS regulations at 42 CFR 413.337(b)(4)(ii) to reflect this permanent cap on wage index reductions. Additionally, we finalized a policy that a new SNF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new SNF would not have a wage index in the prior FY. A full discussion of the adoption of this policy is found in the FY 2023 SNF PPS final rule.

As stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423, respectively), this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index. OMB issued further revised CBSA delineations in OMB Bulletin No. 20–01, on March 6, 2020 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). However, we determined that the changes in OMB Bulletin No. 20–01 do not impact the CBSA-based labor market area delineations adopted in FY 2021. Therefore, we did not propose adopting the revised OMB delineations identified in OMB Bulletin No. 20–01 for FY 2022 through FY 2024.

On July 21, 2023, OMB issued OMB Bulletin No. 23–01, which updates and supersedes OMB Bulletin No. 20–01 based on the decennial census. OMB Bulletin No. 23–01 revised delineations for CBSAs which are made up of counties and equivalent entities (for example, boroughs; a city and borough, and a municipality in Alaska; planning regions in Connecticut; parishes in Louisiana; municipios in Puerto Rico; and independent cities in Maryland, Missouri, Nevada, and Virginia). As stated in the FY 2025 SNF PPS final rule (89 FR 64059), we adopted the revised OMB delineations identified in OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*). OMB has not published further delineation revisions since OMB Bulletin No. 23–01. Therefore, for FY 2027, we proposed to maintain the current CBSA delineations. The wage index applicable to FY 2027 is set forth in Table A and B, available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

Once calculated, we will apply the wage index adjustment to the labor-related share of the Federal rate. Each year, we calculate a labor-related share, based on the relative importance of labor-related cost categories (that is, those cost categories that are labor-intensive and vary with the local labor market) in the input price index. In the FY 2025 SNF final rule (89 FR 64060), we finalized a proposal to revise the labor-related share to reflect the relative importance of the 2022-based SNF market basket cost weights for the following cost categories: Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services; and a proportion of Capital-Related expenses. The methodology for calculating the labor-related-share beginning in FY 2025 is discussed in detail in the FY 2025 SNF PPS final rule (89 FR 64080 through 64081).

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related share of the total costs after accounting for historical and projected price changes between the base year and FY 2027. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2027 than the base year weights from the SNF market basket. We calculate the labor-related relative importance for FY 2027 in four steps. First, we compute the FY 2027 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2027 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2027 relative importance for each cost category by multiplying this ratio by the base year (2022) weight. Finally, we add the FY 2027 relative importance for each of the labor-related cost categories (Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services; and a portion of Capital-Related expenses) to produce the proposed FY 2027 labor-related share.

TABLE 7—LABOR-RELATED SHARE, FY 2026 AND FY 2027

	Relative importance, labor-related share, FY 2026 25:2 forecast [1]	Relative importance, proposed labor-related share, FY 2027 25:4 forecast [2]
Wages and Salaries	53.4	53.5
Employee Benefits	8.9	8.9
Professional Fees: Labor-Related	3.6	3.6
Administrative & Facilities Support Services	0.4	0.4
Installation, Maintenance & Repair Services	0.5	0.5
All Other: Labor-Related Services	2.0	2.0
Capital-Related (0.391 * Capital RI)	3.1	3.1
Total	71.9	72.0

[1] Published in the **Federal Register**; Based on the second quarter 2025 IHS Global Inc. forecast of the 2022-based SNF market basket.
[2] Based on the fourth quarter 2025 IHS Global Inc. forecast of the 2022-based SNF market basket. The relative importance of capital for FY 2027 is forecasted to be 8.0 percent.

To calculate the labor portion of the case-mix adjusted per diem rate, we will multiply the total case-mix adjusted per diem rate, which is the sum of all five case-mix adjusted components into which a patient classifies, and the non-case-mix component rate, by the FY 2027 labor-related share percentage provided in Table 7. The remaining portion of the rate will be the nonlabor portion. Under the previous RUG–IV model, we included tables which provided the case-mix adjusted RUG–IV rates, by RUG–IV group, broken out by total rate, labor portion and non-labor portion, such as Table 8 of the FY 2019 SNF PPS final rule (83 FR 39175). However, as we discussed in the FY 2020 SNF PPS final rule (84 FR 38738), under PDPM, as the total rate is calculated as a combination of six different component rates, five of which are case-mix adjusted, and given the sheer volume of possible combinations of these five case-mix adjusted components, it is not feasible to provide tables similar to those that existed in the prior rulemaking.

Therefore, to aid interested parties in understanding the effect of the wage index on the calculation of the SNF per diem rate, we have included a hypothetical rate calculation in Table 9.

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made if the wage adjustment had not been made. For FY 2027 (Federal rates effective October 1, 2026), we apply an adjustment to fulfill the budget neutrality requirement. We meet this requirement by multiplying each of the components of the unadjusted Federal rates by a budget neutrality factor, equal to the ratio of the

weighted average wage adjustment factor for FY 2026 to the weighted average wage adjustment factor for FY 2027. For this calculation, we will use the same FY 2025 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor portion of the rate component multiplied by the wage index plus the non-labor portion of the rate component. The budget neutrality factor for FY 2027 is 0.9987.

We also propose that if more recent data becomes available (for example, revised wage data and/or updated claims data), we would use such data, if appropriate, to determine the wage index budget neutrality factor in the SNF PPS final rule.

E. SNF Value-Based Purchasing Program

Beginning with payment for services furnished on October 1, 2018, section 1888(h) of the Act requires the Secretary to reduce the adjusted Federal per diem rate determined under section 1888(e)(4)(G) of the Act otherwise applicable to a SNF for services furnished during a FY by 2 percent, and to adjust the resulting rate for a SNF by the value-based incentive payment amount earned by the SNF based on the SNF's performance score for that FY under the SNF VBP Program. To implement these requirements, we finalized- in the FY 2019 SNF PPS final rule the addition of 42 CFR 413.337(f) to our regulations (83 FR 39178).

We refer readers to section VII. of this proposed rule for further discussion of the updates we are proposing for the SNF VBP Program.

F. Adjusted Rate Computation Example

Tables 8 through 10 provide examples generally illustrating payment calculations during FY 2027 under PDPM for a hypothetical 30-day SNF stay, involving the hypothetical SNF XYZ, located in Frederick, MD (Urban CBSA 23224), for a hypothetical patient who is classified into such groups that the patient's HIPPS code is NHNC1. Table 8 shows the adjustments made to the Federal per diem rates (prior to application of any adjustments under the SNF VBP Program as discussed) to compute the provider's case-mix adjusted per diem rate for FY 2027, based on the patient's PDPM classification, as well as how the variable per diem (VPD) adjustment factor affects calculation of the per diem rate for a given day of the stay. Table 9 shows the adjustments made to the case-mix adjusted per diem rate from Table 8 to account for the provider's wage index. The wage index used in this example is based on the FY 2027 SNF PPS wage index that appears in Table 8 available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Finally, Table 10 provides the case-mix and wage index adjusted per-diem rate for this patient for each day of the 30-day stay, as well as the total payment for this stay. Table 10 also includes the VPD adjustment factors for each day of the patient's stay, to clarify why the patient's per diem rate changes for certain days of the stay. As illustrated in Table 10, SNF XYZ's total PPS payment for this patient's stay would equal $23,414.49.

TABLE 8—PDPM CASE-MIX ADJUSTED RATE COMPUTATION EXAMPLE

Per diem rate calculation				
Component	Component group	Component rate	VPD adjustment factor	VPD adjusted rate
PT	N	$108.43	1.00	$108.43
OT	N	102.37	1.00	102.37
SLP	H	78.08	1.00	78.08
Nursing	N	198.44	1.00	198.44
NTA	C	177.22	3.00	531.66
Non-Case-Mix	.....	120.89	.....	120.89
Total PDPM Case-Mix Adjustment Per Diem	.....	.....	.....	1,139.87

TABLE 9—WAGE INDEX ADJUSTED RATE COMPUTATION EXAMPLE

PDPM wage index adjustment calculation						
HIPPS code	PDPM case-mix adjusted per diem	Labor portion	Wage index	Wage index adjusted rate	Non-labor portion	Total case mix and wage index adj. rate
NHNC1	$1,139.87	$820.71	0.9346	$767.04	$319.16	$1,086.20

TABLE 10—ADJUSTED RATE COMPUTATION EXAMPLE

Day of stay	NTA VPD adjustment factor	PT/OT VPD adjustment factor	Case-mix and wage index adjusted per diem rate
1	3.00	1.00	$1,086.20
2	3.00	1.00	1,086.20
3	3.00	1.00	1,086.20
4	1.00	1.00	748.45
5	1.00	1.00	748.45
6	1.00	1.00	748.45
7	1.00	1.00	748.45
8	1.00	1.00	748.45

TABLE 10—ADJUSTED RATE COMPUTATION EXAMPLE—Continued

Day of stay	NTA VPD adjustment factor	PT/OT VPD adjustment factor	Case-mix and wage index adjusted per diem rate
9	1.00	1.00	748.45
10	1.00	1.00	748.45
11	1.00	1.00	748.45
12	1.00	1.00	748.45
13	1.00	1.00	748.45
14	1.00	1.00	748.45
15	1.00	1.00	748.45
16	1.00	1.00	748.45
17	1.00	1.00	748.45
18	1.00	1.00	748.45
19	1.00	1.00	748.45
20	1.00	1.00	748.45
21	1.00	0.98	744.43
22	1.00	0.98	744.43
23	1.00	0.98	744.43
24	1.00	0.98	744.43
25	1.00	0.98	744.43
26	1.00	0.98	744.43
27	1.00	0.98	744.43
28	1.00	0.96	740.41
29	1.00	0.96	740.41
30	1.00	0.96	740.41
Total Payment	.....	.....	23,414.49

IV. Additional Aspects of the SNF PPS

A. SNF Level of Care—Administrative Presumption

The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system outlined in section IV.C. of this proposed rule. This approach includes an administrative presumption that utilizes a beneficiary's correct assignment, at the outset of the SNF stay, of one of the case-mix classifiers designated for this purpose to assist in making certain SNF level of care determinations.

In accordance with 42 CFR 413.345, we include in each update of the Federal payment rates in the **Federal Register** a discussion of the resident classification system that provides the basis for case-mix adjustment. We also designate those specific classifiers under the case-mix classification system that represent the required SNF level of care, as provided in 42 CFR 409.30. This designation reflects an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial Medicare assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment.

A beneficiary who does not qualify for the presumption is not automatically classified as either meeting or not meeting the level of care definition but instead receives an individual determination on this point using the existing administrative criteria. This presumption recognizes the strong likelihood that those beneficiaries who are correctly assigned one of the designated case-mix classifiers during the immediate post-hospital period would require a covered level of care, which would be less likely for other beneficiaries.

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. The FY 2018 final rule (82 FR 36544) further specified that we would henceforth disseminate the standard description of the administrative presumption's designated groups via the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html* (where such designations appear in the paragraph entitled ''Case-Mix Adjustment'') and would publish such designations in rulemaking only to the extent that we actually intend to propose changes in them. Under that approach, the set of case-mix classifiers designated for this purpose under PDPM was finalized in the FY 2019 SNF PPS final rule (83 FR 39253) and is posted on the SNF PPS website (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html*), in the paragraph entitled ''Case Mix Adjustment.''

However, we note that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that any services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. As previously stated in the FY 2000 SNF PPS final rule (64 FR 41667), the administrative presumption is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations where the sole classifier that triggers the presumption is itself assigned through the receipt of services that are subsequently determined to be not reasonable and necessary. Moreover,

we want to stress the importance of careful monitoring for changes in each patient's condition to determine the continuing need for Medicare Part A SNF benefits after the ARD of the initial Medicare assessment.

B. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA 1997) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor (MAC) for almost all the services that its residents receive during a covered Part A stay. In addition, section 1862(a)(18) of the Act places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. Section 1888(e)(2)(A) of the Act excludes a small list of services from the consolidated billing provision (primarily those services furnished by physicians and certain other types of practitioners), which remain separately billable under Medicare Part B when furnished to a SNF's Part A resident. These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998, interim final rule (63 FR 26295 through 26297). Effective with services furnished on or after January 1, 2024, section 4121(a)(4) of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117–328, enacted December 29, 2022) added marriage and family therapists and mental health counselors to the list of practitioners at section 1888(e)(2)(A)(ii) of the Act whose services are excluded from the consolidated billing provision.

Section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999) (Pub. L. 106–113, enacted November 29, 1999) amended section 1888(e)(2)(A)(iii) of the Act by further excluding a number of individual high-cost, low-probability services, identified by HCPCS codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA 1999 amendment in greater detail in the FY 2001 SNF PPS proposed and final rules (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *www.cms.gov/transmittals/downloads/ab001860.pdf.*

As explained in the FY 2001 proposed rule (65 FR 19232), the amendments enacted in section 103 of the BBRA 1999 not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary the authority to designate certain additional, individual services for exclusion within each of these four specified service categories. In the FY 2001 SNF PPS proposed rule, we stated that the BBRA 1999 Conference report (H.R. Conf. Rep. No. 106–479 at 854 (1999)) characterizes the individual services that this legislation targets for exclusion as high-cost, low-probability events that could have devastating financial impacts because their costs far exceed the payment SNFs receive under the PPS. According to the conferees, section 103(a) of the BBRA 1999 is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. By contrast, the amendments enacted in section 103 of the BBRA 1999 do not designate for exclusion any of the remaining services within those four categories (thus, leaving all those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

Effective with items and services furnished on or after October 1, 2021, section 134 in Division CC of the CAA, 2021 (Pub. L. 116–260) established an additional fifth category of excluded codes in section 1888(e)(2)(A)(iii)(VI) of the Act, for certain blood clotting factors for the treatment of patients with hemophilia and other bleeding disorders along with items and services related to the furnishing of such factors under section 1842(o)(5)(C) of the Act. Like the provisions enacted in the BBRA 1999, section 1888(e)(2)(A)(iii)(VI) of the Act gives the Secretary the authority to designate additional items and services for exclusion within the category of items and services related to blood clotting factors, as described in that section.

A detailed discussion of the legislative history of the consolidated billing provision is available on the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_2018-10-01.pdf.*

As stated in the FY 2001 SNF PPS final rule (65 FR 46790), and as is consistent with our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA 1999: they must fall within one of the five service categories specified in the BBRA 1999 and CAA, 2021; and they also must meet the same standards of high-cost and low-probability in the SNF setting, as discussed in the BBRA 1999 Conference report. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion within the defined categories as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice) (65 FR 46791).

In the FY 2001 SNF PPS proposed rule, we specifically solicited public comments identifying HCPCS codes in any of these five service categories (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices, and blood clotting factors) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. We stated in the FY 2001 SNF PPS proposed rule that we may consider excluding a particular service if it meets our criteria for exclusion. We requested that commenters identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We also stated in the FY 2001 SNF PPS proposed rule that the original BBRA amendment and the CAA, 2021 identified a set of excluded items and services by means of specifying individual HCPCS codes within the designated categories that were in effect as of a particular date (in the case of the BBRA 1999, July 1, 1999, and in the case of the CAA, 2021, July 1, 2020), as subsequently modified by the Secretary. In addition, as stated in the FY 2001 SNF PPS proposed rule, the statute (sections 1888(e)(2)(A)(iii)(II) through (VI) of the Act) gives the Secretary authority to identify additional items and services for exclusion within the five specified categories of items and services described in the statute, which are also designated by HCPCS code. Designating the excluded services in this manner makes it possible for us to utilize program issuances as the vehicle for accomplishing routine updates to the

excluded codes to reflect any minor revisions that might subsequently occur in the coding system itself, such as the assignment of a different code number to a service already designated as excluded, or the creation of a new code for a type of service that falls within one of the established exclusion categories and meets our criteria for exclusion.

Accordingly, if we identify through the current rulemaking cycle any new services that meet the criteria for exclusion from SNF consolidated billing, we will identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, October 1, 2024). By making any new exclusions in this manner, we can similarly accomplish routine future updates of these additional codes through the issuance of program instructions. The latest list of excluded codes can be found on the SNF Consolidated Billing website at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling.*

C. Payment for SNF-Level Swing-Bed Services

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF-level care, as needed. For critical access hospitals (CAHs), Medicare Part A pays on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement. However, in accordance with- section 1888(e)(7) of the Act, SNF-level services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. As stated in the FY SNF 2002 PPS final rule (66 FR 39562), this effective date is consistent with the statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. As finalized in the FY 2010 SNF PPS final rule (74 FR 40356 through 40357), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment, which is limited to the required demographic, payment, and quality items. As stated in the FY 2019 SNF PPS final rule (83 FR 39235), revisions were made to the swing bed assessment to support implementation of PDPM, effective October 1, 2019. A discussion of the assessment schedule and the MDS effective beginning FY 2020 appears in the FY 2019 SNF PPS final rule (83 FR 39229 through 39237). The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.*

V. Other SNF PPS Issues

A. Technical Updates to the PDPM ICD–10 Mappings

1. Background

In the FY 2019 SNF PPS final rule (83 FR 39162), we finalized the implementation of the Patient-Driven Payment Model (PDPM), effective October 1, 2019. The PDPM uses International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10) diagnosis codes in several ways, including assigning beneficiaries to clinical categories under the PT, OT, SLP, and NTA components based on the beneficiary's primary diagnosis. Although additional ICD–10 codes may be reported as secondary diagnoses and recognized as comorbidities, the PDPM does not use secondary diagnoses to assign beneficiaries to clinical categories. The ICD–10 code to clinical category mappings and the ICD–10 code to SLP comorbidity mappings and ICD–10 code to NTA comorbidity mappings (collectively referred to as the PDPM ICD–10 code mappings) are available on the CMS website: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.*

In the FY 2020 SNF PPS final rule (84 FR 38750), we described the process for maintaining and updating the PDPM ICD–10 code mappings, as well as the SNF Grouper software and other related patient classification and billing products, to ensure they reflect the most current ICD–10 codes. Beginning with FY 2020 updates, we have implemented non-substantive changes to the PDPM ICD–10 code mappings through a sub-regulatory process by posting the updated mappings on the CMS website: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.* Such non-substantive changes are limited to changes necessary to maintain consistency with the most current PDPM ICD–10 code mappings.

Substantive changes that extend beyond maintaining consistency with the most current PDPM ICD–10 code mappings—such as changes to the assignment of a diagnosis code to a clinical category or comorbidity list—are implemented through notice-and-comment rulemaking, as these changes affect payment policy. As stated in the proposed rule, the classification of diagnoses to the ''Return to Provider'' clinical category, whether currently mapped or proposed to be mapped, is not intended to reflect any judgment regarding the clinical significance of these conditions or the importance of their recognition and treatment. Rather, we believe there are more specific or appropriate diagnoses that better reflect the primary reason for a Medicare Part A-covered SNF stay.

2. Clinical Category Changes for New ICD–10 Codes for FY 2027

For FY 2027, we did not identify any substantive changes to the PDPM ICD–10 code mappings. We identified only non-substantive updates, which do not alter policy or payment methodology. Consistent with prior practice, we implemented these non-substantive updates through a sub-regulatory process by posting the revised PDPM ICD–10 code mappings on the CMS website.

3. Request for Information: Methodology for Quantifying and Addressing Case-Mix Creep Under the Patient Driven Payment Model

a. Background

On October 1, 2019, we implemented the Patient Driven Payment Model (PDPM) under the SNF PPS, a new case-mix classification model that replaced the prior case-mix classification model, the Resource Utilization Groups, Version IV (RUG–IV). The previous RUG–IV model classified most patients into a therapy payment group and primarily used the volume of therapy services provided to the patient as the basis for payment classification, thus creating an incentive for SNFs to furnish therapy regardless of the individual patient's unique characteristics, goals, or needs. The PDPM uses clinical data from the Minimum Data Set (MDS), a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid, consistent with the provisions of section 1888(e)(4)(G)(i) of the Act.

As discussed in the FY 2019 SNF PPS final rule (83 FR 39256), as with prior system transitions, we proposed and finalized implementing PDPM in a budget neutral manner. This means that the transition to PDPM, along with the related policies finalized in the FY 2019

SNF PPS final rule, were not intended to result in an increase or decrease in the aggregate amount of Medicare Part A payment to SNFs. We believe ensuring parity is integral to the process of providing ''for an appropriate adjustment to account for case-mix'', such mix shall be based on appropriate data in accordance with section 1888(e)(4)(G)(i) of the Act. Section V.I. of the FY 2019 SNF PPS final rule (83 FR 39255 through 39256) discusses the methodology that we used to implement PDPM in a budget neutral manner.

Since PDPM implementation, we have closely monitored SNF utilization data to determine if the parity adjustment finalized in the FY 2020 SNF PPS final rule (84 FR 38734 through 38735) provided for a budget neutral transition between RUG–IV and PDPM. In the FY 2023 SNF PPS final rule (87 FR 22737 through 22743), we finalized the FY 2023 SNF PPS Parity Adjustment Methodology so that the PDPM was implemented in a budget-neutral manner using a parity adjustment based on expected payments under RUG–IV. More specifically, projected aggregate payments using RUG–IV data were applied to the case-mix indexes (CMIs) to avoid a change in aggregate payment under PDPM. Subsequent monitoring indicated that actual payments under PDPM exceeded expected levels, leading CMS to implement a 4.6 percent parity adjustment recalibration phased in over two years.

As PDPM has matured, CMS has continued to monitor case-mix trends to ensure that payment remains aligned with actual patient acuity rather than changes in coding practices. CMS has collected data that reflects coding behavior after the initial transition years under the PDPM. With the COVID–19 Public Health Emergency (PHE) ending in May 2023, CMS has collected more recent data that better reflect trends in typical care delivery and utilization patterns following the establishment of PDPM as the SNF payment system.

As in the case Proposed Parity Adjustment Methodology finalized in the FY 2023 SNF PPS final rule (87 FR 47525 through 47534), Section 1888(e)(4)(F) of the Social Security Act authorizes CMS to address ''changes in the coding or classification of residents that do not reflect the real changes in case mix'' by adjusting SNF per-diem rates to ''eliminate the effect of such coding or classification changes.'' Consistent with that authority, CMS is developing a regression framework to quantify the extent to which recent case-mix trends may reflect nominal coding changes, commonly referred to as ''case-mix creep.''

b. Observed Case-Mix Trends

These data suggest significant increases in certain case-mix indexes (CMIs) that are unlikely to reflect underlying health status trends in the patient population. For example, reporting of the malnutrition item (I5600) increased from a rate of 5 percent of stays prior to PDPM implementation to 47 percent in FY 2024. Although only a small number of items demonstrate changes of this magnitude, many others show smaller but meaningful shifts. For example, swallowing disorder (K0100) increased from 4 percent to 21 percent and depression (D0160 or D0600) increased from 4 percent to 19 percent. Some items also show declines, such as fever (J1550A) which decreased from 2 percent to 1 percent.

More broadly, as described at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research,* CMS has observed that average CMIs have increased at a rate that exceeds what would be expected based solely on changes in patient health status, while median per-diem costs, which reflect patient resource utilization, have declined. For example, the median per-diem PT costs decreased from $67 to $51, median per-diem OT costs decreased from $58 to $45, median per-diem SLP costs decreased from $34 to $28, and median per-diem NTA costs decreased from $43 to $39. This divergence suggests a potential disconnect between reported acuity and observed resource utilization. Collectively, these patterns underscore the need for a systematic approach to evaluating how much observed case-mix growth reflects real changes versus changes in coding or documentation.

c. Policy Rationale

As CMS continues monitoring case-mix trends to ensure that payment remains aligned with actual patient acuity rather than changes in coding practices, recent data suggests significant increases in certain CMIs that are unlikely to reflect underlying health status trends of the patients. These patterns underscore the need to address how much observed case-mix growth reflects real changes versus changes in coding or documentation and to make the appropriate adjustments.

CMS is exploring a potential approach that addresses the issue and considers the changing patient caseload as well as underlying real-time trends. This Request for Information is intended to receive feedback from stakeholders on CMS observations of case-mix creep issue in the PDPM and of the approach to address it. The following section includes details of the methodology that CMS is considering for addressing the case-mix creep that could be included in future rulemaking.

d. Methodology Overview

(1) Definitions and Conceptual Foundations

PDPM is designed to classify beneficiaries based on clinical characteristics and service needs associated with resource use to determine appropriate Medicare payment. Patient acuity reflects a combination of diagnostic factors, comorbidities, functional status, and treatment needs. The payment items, relying on both claims and assessment data, are designed to capture differences in resource needs across patient acuity groups, or PDPM case-mix groups (CMGs), measured by a concise set of items that represent those clinical complexity factors.

CMGs are determined by the composition of payment items across the five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing. Each component has its own set of clinical complexity factors or payment items, and by extension, its own set of CMGs.

Changes in case-mix over time can be assessed by examining changes in the distribution of CMGs. The Case-Mix Index (CMI), a numerical representation of CMGs, provides a summary measure of case-mix for each component. Increases in average CMIs indicate higher reported patient acuity and higher expected resource needs. This is a key feature that makes CMIs crucial for measuring case-mix changes and that other payment elements, such as base rates which only reflect average resource use, do not possess.

For analytic purposes, ''Total Case-Mix Change'' is defined as the overall observed change in CMGs and CMIs. This total change can be separated into three components:

- *Real Population Health and Utilization Changes (RPHU):* Changes in beneficiary demographics, clinical conditions, service needs, and system-level utilization patterns.
- *Real Time Trends:* Systematic changes over time that occur independently of PDPM.
- *Nominal Change:* Changes in coding or classification that do not reflect real change in patient acuity and may indicate case-mix upcoding.

The analysis described in this RFI focuses on quantifying the ''Nominal Change'' component. A detailed

description of the analytic framework, including the study period, data sources, and regression setup, is available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research.*

Real Population Health and Utilization Changes refer to shifts in the characteristics and care needs of SNF beneficiaries, as well as broader trends in how and where patients receive post-acute care. These include demographic factors such as age, sex, and race; clinical diagnoses and service needs; growth in Medicare Advantage (MA) enrollment; and changes in site-of-care patterns across post-acute care settings.

To assess the degree to which observed case-mix changes reflect real shifts in patient needs, CMS evaluates measures derived from pre-SNF inpatient claims and selected non-payment items of MDS admission assessments that are less sensitive to PDPM coding incentives. Real Time Trends represent systematic, non-random changes over time that are not attributable to PDPM itself. To estimate these trends, CMS uses a study period that spans FY 2017 through FY 2024, allowing pre-PDPM years to establish baseline SNF patterns unrelated to the PDPM payment structure. These estimated trends are projected into the PDPM period to help isolate changes that would have been expected based on historical patterns alone.

Nominal Changes refer to the portion of observed case-mix growth that may result from changes in coding or classification practices rather than from actual changes in patient acuity. These changes are the primary focus of this analysis, as they may affect reported case-mix levels without reflecting differences in clinical need.

Because PDPM payment is determined by a combination of several interacting payment items, it is difficult to attribute nominal changes to specific diagnoses or codes. To assess these effects, CMS evaluates case-mix creep at the PDPM component level by examining the full distribution of case-mix groups (CMGs). The component-specific Case-Mix Index (CMI) provides a single summary measure of these distributions and serves as a practical metric for quantifying nominal changes in case-mix over time.

(2) Adjustment Factor Determination

Table 11 includes the PDPM component-level adjustment factors calculated using the methodology for quantifying case-mix creep. The Average Actual CMI represents the actual case-mix index that occurred between FY 2020 and FY 2024 after adjusting for parity, reflecting real population health changes, utilization patterns, real-time trends, and nominal changes. The Average Target CMI represents the estimated case-mix index over the same period that accounts for real population and utilization changes and real-time trends but removes nominal shifts in coding or classification. The ratio of Target to Actual is the Case-Mix Creep Adjustment Factor.

Based on the data of this analysis, the factors would be implemented through the CMI or the base rate for each component: +3.3 percent for PT, +4.1 percent for OT, −15.9 percent for SLP, −1.9 percent for NTA, and −10.6 percent for Nursing.

Alternatively, if a system-wide PDPM case-mix creep adjustment factor is implemented, the resulting adjustment factor would be 0.957, which can also be interpreted as a blanket 4.3 percent reduction in CMIs or base rates, or a 3.6 percent reduction in total payment across the payment system, which also includes the non-case-mix portion of payment.

TABLE 11—PDPM COMPONENT-LEVEL CASE-MIX CREEP ADJUSTMENT FACTORS

Component	Average actual CMI	Average target CMI	Case-mix creep adjustment factor
PT	1.440	1.487	1.033 (3.3% increase).
OT	1.439	1.498	1.041 (4.1% increase).
SLP	1.714	1.441	0.841 (15.9% decrease).
NTA	1.227	1.204	0.981 (1.9% decrease).
Nursing	1.661	1.485	0.894 (10.6% decrease).
Case-Mix Total			0.957 (4.3% decrease).

e. Request for Information

CMS is requesting information on the aforementioned approach to identify and address case-mix creep. Specifically, CMS invites the public to comment on the following:

- The overall methodology for quantifying case-mix creep, including the conceptual framework that separates total case-mix change into real population health and utilization changes, real-time trends, and nominal changes.
- The data sources and measures used to assess real population health and utilization changes, including the use of pre-SNF inpatient claims and selected non-payment MDS items.
- The approach to estimating real-time trends using a study period spanning FY 2017 through FY 2024.
- Alternative approaches to implementing case-mix creep adjustments, including component-specific adjustments versus a system-wide adjustment factor.
- Any other considerations CMS should consider when finalizing a methodology to address case-mix creep in future rulemaking.

Comments should be submitted in accordance with the instructions provided elsewhere in this rule.

4. IPPS Wage Index

For FY 2027, we are proposing to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the SNF wage index. We continue to consider this an appropriate source of wage index to estimate costs per day, in accordance with our longstanding wage index policy at 42 CFR 413.337(b)(4). At the same time, we routinely assess whether more recent or alternative data sources may further enhance the accuracy and representativeness of our estimates We note that other payment systems have explored and are exploring alternative wage index methodologies under their specific programmatic and statutory circumstances. For example, CMS finalized changes to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) wage index using Bureau of Labor Statistics (BLS) occupation-level wage data in the CY 2025 ESRD PPS final rule (89 FR 89116). While this approach was developed under the specific programmatic and statutory circumstances of the ESRD PPS and may not be directly transferable to the SNF

PPS, CMS is interested in exploring whether similar methodologies using publicly available wage data could be adapted to better reflect the geographic variation in labor costs for Skilled Nursing Facilities.

In its 2023 Report to Congress,[2] Medicare Payment Advisory Commission (MedPAC) discussed various conceptual approaches to Medicare wage indexes, including the use of county-level wage data from BLS with an occupational mix to construct wage indexes that are more specific to the payment setting. MedPAC has previously written about using all-employer, occupation-level wage data to establish different weights for setting-specific occupational labor mixes as one approach to geographic adjustments.

We are soliciting comments on whether we should consider using alternative data sources to construct an SNF-specific wage index for potential use in future years. CMS seeks feedback to better understand the potential advantages and limitations of using alternative data sources, such as BLS data and SNF cost reports, as well as other methodologies that stakeholders believe could appropriately reflect the geographic variation in labor costs for skilled nursing facilities. In addition, as discussed elsewhere in the **Federal Register**, we note that we are also considering the potential use of alternative data sources in other payment systems including the Inpatient Rehabilitation Facilities PPS, Inpatient Psychiatric Facilities PPS, and Hospice payment system. We seek feedback on the unique considerations applicable to SNFs that should inform how CMS could consider the potential use of alternative data sources.

VI. Skilled Nursing Facility Quality Reporting Program (SNF QRP)

A. Background and Statutory Authority

The SNF QRP is authorized by section 1888(e)(6) of the Act. The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-critical access hospital (CAH) swing-bed rural hospitals. Section 1888(e)(6)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual market basket percentage increase described in section 1888(e)(5)(B)(i) of the Act applicable to a SNF for a FY, after application of section 1888(e)(5)(B)(ii) of the Act (the productivity adjustment) and section 1888(e)(5)(B)(iii) of the Act, in the case of a SNF that does not submit data in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for that FY. Section 1890A of the Act requires that the Secretary establish and follow a pre-rulemaking process, in coordination with the consensus-based entity (CBE) with a contract under section 1890(a) of the Act, to solicit input from certain groups regarding the selection of quality and efficiency measures for the SNF QRP. We have codified our program requirements at § 413.360.

In sections VI.C. and VI.D. of this proposed rule, we are proposing to remove two measures, specifically the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure and the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, beginning with the FY 2028 SNF QRP. In section VI.F.2. of this proposed rule, we are proposing to revise the SNF QRP data submission deadlines beginning with the FY 2029 SNF QRP. We are also proposing to require the submission of MDS data on each resident receiving covered skilled care in a SNF, regardless of payer, beginning with the FY 2031 SNF QRP as described in section VI.F.3. of this proposed rule. Finally, we are soliciting public comments on one Request for Information (RFI) on future measure concepts for the SNF QRP in section VI.E. of this proposed rule.

B. General Considerations Used for the Selection of Measures for the SNF QRP

For a detailed discussion of the considerations that we historically used for the selection of quality, resource use, or other measures for the SNF QRP, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46429 through 46431).

The SNF QRP currently has 15 adopted measures, which are set forth in Table 12. We did not propose to adopt any new measures for the SNF QRP in this proposed rule.

For a discussion of the factors we use to evaluate whether a measure must be removed from the SNF QRP, we refer readers to our regulations at 42 CFR 413.360(b)(2) and to the FY 2019 SNF PPS final rule (83 FR 39267 through 39269).

TABLE 12—QUALITY MEASURES CURRENTLY ADOPTED FOR THE SNF QRP

Short name	Measure name and data source
Assessment-Based	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients.
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients.
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post Acute Care (PAC).
TOH-Patient	Transfer of Health (TOH) Information to the Patient Post Acute Care (PAC).
DC Function	Discharge Function Score.
Patient/Resident COVID–19 Vaccine	COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date.
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

[2] *https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf.*

TABLE 12—QUALITY MEASURES CURRENTLY ADOPTED FOR THE SNF QRP—Continued

Short name	Measure name and data source
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization.
National Healthcare Safety Network	
HCP COVID–19 Vaccine	COVID–19 Vaccination Coverage among Healthcare Personnel (HCP).
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP).

C. Proposal To Remove the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning With the FY 2028 SNF QRP

We refer readers to the FY 2022 SNF PPS final rule where we adopted the COVID–19 Vaccination Coverage among HCP measure (HCP COVID–19 Vaccine measure) into the SNF QRP (86 FR 42480 through 42489) and the FY 2024 SNF PPS final rule where we modified the HCP COVID–19 Vaccine measure to account for updated COVID–19 vaccine guidance (88 FR 53223 through 53233). The HCP COVID–19 Vaccine measure requires SNFs to report the COVID–19 vaccination status of HCP through the National Healthcare Safety Network (NHSN). SNFs must collect current vaccination status for all employees, licensed independent practitioners, adult trainees, students, and volunteers, as well as certain contract personnel one week out of each month and report these data on a quarterly basis (88 FR 53227).

We are proposing to remove the HCP COVID–19 Vaccine measure beginning with the FY 2028 SNF QRP under measure removal Factor 3: a measure does not align with current clinical guidelines or practice (42 CFR 413.360(b)(2)(iii)).

When we originally adopted this measure, the United States was in the midst of a Public Health Emergency (PHE) with millions of COVID–19 cases and over 550,000 COVID–19 deaths (86 FR 42480). In March 2021, when this measure was being proposed, the United States was averaging over 5,000 deaths per week. In April 2023, the last full month of the PHE, the weekly number of deaths due to COVID–19 averaged around 1,300.[3] While preventing the spread of COVID–19 remains a public health goal, the PHE ended on May 11, 2023,[4] and the COVID–19 death rate has continued to decrease. The weekly number of deaths attributed to COVID–19 during the past 6 months (weeks ending 8/2/25 through 1/31/26) ranged from 188 to 488.[5]

With the end of the PHE and decrease in COVID–19 deaths, we believed the continued costs and burden to providers of reporting on this measure outweighed the benefit of continued information collection on the HCP COVID–19 Vaccine measure in several settings. We have already removed this measure from the Hospital Inpatient Quality Reporting Program (90 FR 37010 through 37012), the Inpatient Psychiatric Facility Quality Reporting Program (90 FR 37657 through 37658), the Ambulatory Surgical Center Quality Reporting (90 FR 53917 through 53919), the Hospital Outpatient Quality Reporting Programs (90 FR 53917 through 53919), and the Inpatient Rehabilitation Facility Quality Reporting Program (90 FR 37700 through 37702).

Since the end of the PHE, the CDC's clinical recommendations for COVID–19 vaccination have changed. In December 2020, the CDC's Advisory Committee on Immunization Practices (ACIP) recommended that HCP should receive a complete vaccination course.[6] In the FY 2024 SNF PPS final rule, we modified the measure to utilize the term ''up to date'' in the HCP vaccination definition to stay aligned with evolving CDC guidance, and we indicated the definition of ''up to date'' may change based on CDC's latest guidelines (88 FR 53228). At the time the HCP COVID–19 Vaccine measure was adopted in August 2021, vaccination was a critical part of the nation's strategy to effectively counter the spread of COVID–19 in an effort to restore societal functioning.[7] There were well-defined parameters for receiving the COVID–19 vaccination intended to capture routine, catch-up, and risk-based immunization recommendations.

However, these parameters no longer apply, due to evolving circumstances. The latest CDC COVID–19 vaccination recommendations for the 2025–2026 season are now based on shared clinical decision-making (also known as individual-based decision-making).[8] For shared clinical decision-making, there is not a default decision to vaccinate for a defined population.[9] Given that there is no single default recommendation to vaccinate a defined population, both receipt and nonreceipt of vaccination may be consistent with the application of shared clinical decision-making. This differs from the guidance in place when this measure was finalized.

On this basis, we are proposing to remove the measure from the SNF QRP under removal Factor 3, measure does not align with current clinical guidelines or practice.

If finalized as proposed, SNFs would no longer be required to report CY 2026 HCP COVID–19 Vaccine measure data for purposes of the FY 2028 payment determination (that is, SNFs that do not report CY 2026 HCP COVID–19 Vaccine measure data would not be penalized for the FY 2028 annual payment update under the SNF QRP). Any CY 2026 HCP COVID–19 Vaccine measure data received by CMS would not be used for SNF QRP compliance or public reporting.

We invite public comment on our proposal to remove the COVID–19 Vaccination Coverage among Healthcare Personnel measure from the SNF QRP beginning with the FY 2028 SNF QRP.

[3] Provisional COVID–19 Deaths, by Week, in The United States, Reported to CDC. Accessed on March 27, 2025, via *https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00.*

[4] *https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html.*

[5] Provisional COVID–19 Mortality Surveillance *https://www.cdc.gov/nchs/nvss/vsrr/covid19/.*

[6] A complete vaccination course may require one or more doses depending on the specific vaccine used. 2025–2026 COVID–19 Vaccination Guidance | Covid | CDC.

[7] Centers for Disease Control and Prevention. (2020. COVID–19 Vaccination Program Interim Playbook for Jurisdiction Operations. Accessed March 6, 2026 at *https://www.cdc.gov/vaccines/imz-managers/downloads/Covid-19-Vaccination-Program-Interim_Playbook.pdf.*

[8] 2025–2026 COVID–19 Vaccination Guidance 2025–2026 COVID–19 Vaccination Guidance | Covid | CDC.

[9] ACIP Shared Clinical Decision-Making Recommendations ACIP Shared Clinical Decision-Making Recommendations | ACIP | CDC.

D. Proposal To Remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning With the FY 2028 SNF QRP

We refer readers to the FY 2024 SNF PPS final rule (88 FR 53256 through 53265), where we finalized the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure for the FY 2026 SNF QRP. The measure is an assessment-based process measure that reports the percent of stays in which residents in a SNF are up to date on their COVID–19 vaccinations per the CDC's latest guidance.

We are proposing to remove the Patient/Resident COVID–19 Vaccine measure beginning with the FY 2028 SNF QRP under removal Factor 3: a measure does not align with current clinical guidelines or practice (42 CFR 413.360(b)(2)(iii)).

When we originally adopted the Patient/Resident COVID–19 Vaccine measure, COVID–19 continued to be a major challenge for SNFs, with older adults at a significantly higher risk of mortality, severe disease, and death following infection (88 FR 53256 and 53257). In August 2023, when this measure was adopted, CDC COVID–19 vaccination guidance emphasized population-level vaccination expectations for older adults and other high-risk groups, and the evidence base focused on demonstrating broad protective benefit at the population level. CDC data at that time showed that, among adults aged 50 years and older, individuals who had received a primary vaccination series and booster dose experienced significantly lower risks of COVID–19-related hospitalization and death compared to those who were unvaccinated, and that additional booster doses, including bivalent booster formulations, further reduced the risk of severe outcomes, including hospitalization and death, in the context of emerging variants (88 FR 53257). These data supported an infection prevention framework under which being ''up to date'' with COVID–19 vaccination was treated as a broadly applicable expectation for high-risk populations and therefore appropriate for monitoring through a facility-level quality measure.

At the time the Patient/Resident COVID–19 Vaccine measure was adopted, it was intended to capture routine, catch-up, and risk-based immunization recommendations. In the FY 2024 SNF PPS final rule (88 FR 53264), we recognized that the definition of ''up to date'' may change based on the CDC's latest guidelines. Due to evolving circumstances, the latest CDC COVID–19 vaccination recommendations for the 2025–2026 season are now based on shared clinical decision-making (also known as individual-based decision-making).[10] For shared clinical decision-making, there is not a default decision to vaccinate for a defined population.[11] Given that there is no single default recommendation to vaccinate a defined population, both vaccination and non-vaccination may be consistent with the application of shared clinical decision-making. This differs from the guidance in place when this measure was finalized.

When there were more narrow parameters for receiving the COVID–19 vaccination, the Patient/Resident COVID–19 Vaccine measure promoted consumer transparency and choice by giving consumers clear information on the number of patients in an SNF who were vaccinated. However, these parameters no longer apply in light of current CDC clinical guidance that recommends shared clinical decision-making for COVID–19 vaccination decisions. As a result, both vaccination and non-vaccination may reflect an ''up to date'' status using the guidance of shared clinical decision-making, and the Patient/Resident COVID–19 Vaccine measure may no longer provide information on the prevalence of COVID–19 vaccination in the SNF setting. On this basis, we are proposing to remove the measure from the SNF QRP under removal Factor 3: a measure does not align with current clinical guidelines or practice.

Removing this measure would bring the SNF QRP into alignment with other post-acute care settings since we have already removed this measure from the Home Health Quality Reporting Program (HH QRP) (90 FR 55416 through 55418) and the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) (90 FR 37702 through 37704).

We are proposing that beginning with residents discharged on or after October 1, 2026, SNFs would no longer be required to collect and submit the Patient/Resident COVID–19 Vaccine measure data to CMS. We are also proposing to remove the Resident's COVID–19 vaccination is up to date data element (O0350) from the MDS effective October 1, 2027, since it is not technically feasible to remove this data element earlier. However, under our proposal, this data element would become voluntary and SNFs would not be required to collect and submit Patient/Resident COVID–19 Vaccine measure data beginning with residents discharged on or after October 1, 2026.

We invite public comment on our proposal to remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure from the SNF QRP beginning with the FY 2028 SNF QRP.

E. SNF QRP Quality Measure Concepts Under Consideration for Future Years—Request for Information

In the FY 2024 SNF PPS proposed rule (88 FR 21353 through 21355), we included an RFI on a set of principles for selecting and prioritizing SNF QRP measures, identifying measurement gaps, and suitable measures for filling these gaps. We refer readers to the FY 2024 SNF PPS final rule (88 FR 53265 through 53267) for a summary of the public comments received in response to the RFI.

We are seeking input on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advanced care planning. Advance care planning is a continuous process that supports people in understanding and communicating their goals, values, and preferences regarding future medical decisions.[12] The Patient Self Determination Act of 1990 [13] supports this process by requiring healthcare facilities to inform residents of their rights regarding medical decisions, including advance directives and end of life care.[14] In post-acute care (PAC) settings, where residents recover from acute illness, injury, or major procedures, their needs and goals may evolve as their condition changes. Factors such as clinical stability, functional status, therapy tolerance, cognition function, prognosis, and personal preferences can all shift during recovery. Regular reassessment and transparent communication are essential to maintaining person-centered care, while advance care planning facilitates shared decision-making by documenting resident preferences and

[10] 2025–2026 COVID–19 Vaccination Guidance 2025–2026 COVID–19 Vaccination Guidance | Covid | CDC.

[11] ACIP Shared Clinical Decision-Making Recommendations ACIP Shared Clinical Decision-Making Recommendations | ACIP | CDC.

[12] *https://www.cms.gov/files/document/mln-advanced-care-planning.pdf* McMahan, R.D., Tellez, I., & Sudore, R.L. (2021). Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. *Journal of the American Geriatrics Society, 69*(1), 234–244. *https://doi.org/10.1111/jgs.16801.*

[13] *Public Law 101–508, sections 4206, 4751.*

[14] *https://www.congress.gov/bill/101st-congress/house-bill/5835.*

ensuring goal-concordant care throughout care transitions.[15]

As we review new measure concepts, we will prioritize evidence-based outcome measures that promote person-centered care practices. We are seeking input on the relevant aspects of advanced care planning and measures appropriate for the SNF setting.

F. Form, Manner, and Timing of Data Submission Under the SNF QRP

1. Background

We refer readers to the current regulatory text at 42 CFR 413.360(b) for information regarding the policies for reporting specified data for the SNF QRP.

2. Proposal To Revise SNF QRP Data Submission Deadlines Beginning With the FY 2029 SNF QRP

a. Background

Sections 1899B(f) and (g) of the Act require CMS to provide feedback to SNFs and to publicly report their performance on SNF quality measures specified under section 1899B(c)(1) of the Act and resource use and other measures specified under 1899B(d)(1) of the Act. More specifically, section 1899B(f)(1) of the Act requires the Secretary to provide confidential feedback reports to SNFs on their performance on the quality, resource use, and other measures specified under section 1899B(c)(1) and (d)(1) of the Act. Section 1899B(f)(2) of the Act provides that, to the extent feasible, the Secretary must make these confidential feedback reports available not less frequently than on a quarterly basis except in the case of measures reported on an annual basis, in which case confidential feedback reports may be made available annually. Additionally, section 1899B(g)(1) of the Act requires the Secretary to provide for the public reporting of each SNF's performance on the quality measures, resource use, and other measures specified.

Section 1888(e)(6)(B)(i) of the Act provides the Secretary with discretion to prescribe the manner and the timeframes for SNFs to submit data as specified for reporting for the SNF QRP. For MDS assessment-based measures, in the FY 2017 SNF PPS final rule (81 FR 52041 through 52043), we finalized that SNFs will have approximately 4.5 months after each quarterly data collection period to complete their data submissions and make corrections to such data where necessary. At that time, we received several comments supporting the alignment of the data submission and correction timeframes with other quality reporting programs, but we did not receive any comments on the 4.5-month data submission timeframe. We refer readers to the FY 2017 SNF PPS final rule (81 FR 52041 through 52043) for a discussion of our proposal and summary of comments received and responses thereto.

We also finalized data submission deadlines for SNF QRP measures that are submitted via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). In the FY 2022 SNF PPS final rule (86 FR 42494), we finalized that the COVID–19 Vaccination Coverage among HCP measure is reported to the CDC through the NHSN at least 1 week per month, with the CDC reporting data to CMS quarterly and allowing for corrections in the NHSN application in alignment with the CMS data submission deadlines. In the FY 2023 SNF PPS final rule (87 FR 47555), we finalized that the data collection period for the Influenza Vaccination Coverage among Healthcare Personnel (HCP) measure would be October 1 through March 31, with a data submission deadline of May 15th for each influenza season.

Public reporting of data collected under quality programs, such as the SNF QRP, is designed to provide consumers and their families with the most current information to empower them to make quality-informed decisions about where to receive their care. We have identified that the time between when data on measures is submitted to us and when those data are publicly reported (approximately nine months) may be too long to provide the most accurate and up to date information for the public. For example, through technical expert panels, we have received feedback from resident caregiver advocates that the aged data used in publicly reported quality measures diminishes their value to consumers. Furthermore, we have heard from SNFs that the SNF QRP measure results they receive prior to public reporting are not useful for their quality improvement efforts due to the aged data and the delay in when they receive these reports.

Currently, the largest contributing factor to the 9-month lag between the end of the data collection period and when measures are publicly reported is the 4.5-month timeframe for data submission. Reducing the data submission timeframe from 4.5 months to require data submission the 15th day of the second month after the end of the calendar quarter could reduce this lag by up to 3 months, resulting in more timely public reporting of data for consumers and increasing the value of publicly reported data. Additionally, this timeframe provides SNFs with more recent data in support of their quality improvement activities.

In the FY 2026 SNF PPS proposed rule, we included a request for information (RFI) on reducing the MDS assessment data submission deadline from 4.5 months to 45 days (90 FR 18608). We refer readers to the FY 2026 SNF PPS final rule (90 FR 37343) for a full summary of the public comments received.

b. Proposal To Revise the SNF QRP Assessment Data Submission Deadline

Beginning with the FY 2029 SNF QRP, we are proposing that SNFs must complete their data submissions and make corrections to their MDS assessment data where necessary no later than the 15th day of the second month after the end of the calendar quarter. However, if the 15th day of the second month falls on a Friday, weekend, or Federal holiday, the date is delayed until 11:59 p.m. EST on the next business day. We are proposing that SNFs would follow the deadlines presented in Table 13 for the FY 2029 SNF QRP. We are also proposing that similar calendar year data submission deadlines would apply to future years' payment determinations.

TABLE 13—PROPOSED DATA COLLECTION TIMEFRAME AND DATA SUBMISSION DEADLINES FOR MDS ASSESSMENT DATA AFFECTING THE FY 2029 PAYMENT DETERMINATION

Calendar Year (CY) quarter	Data collection timeframe	Final data submission deadlines for FY 2029 payment determination *
CY 2027 Quarter 1	January 1–March 31, 2027	May 17, 2027.

[15] McMahan RD, Tellez I, Sudore RL. Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. J Am Geriatr Soc. 2021 Jan; 69(1):234–244. doi: 10.1111/jgs.16801. Epub 2020 Sep 7. PMID: 32894787; PMCID: PMC7856112.

TABLE 13—PROPOSED DATA COLLECTION TIMEFRAME AND DATA SUBMISSION DEADLINES FOR MDS ASSESSMENT DATA AFFECTING THE FY 2029 PAYMENT DETERMINATION—Continued

Calendar Year (CY) quarter	Data collection timeframe	Final data submission deadlines for FY 2029 payment determination *
CY 2027 Quarter 2	April 1–June 30, 2027	August 16, 2027.
CY 2027 Quarter 3	July 1–September 30, 2027	November 15, 2027.
CY 2027 Quarter 4	October 1–December 31, 2027	February 15, 2028.

* Data submission deadlines will follow a similar quarterly schedule for subsequent CYs.

We believe that requiring SNFs to submit MDS assessment data by the 15th day of the second month after the end of the calendar quarter is reasonable. We conducted an analysis on the potential impact of reducing the timeframe by determining how many assessments are currently being submitted by this deadline, which is approximately within 45 days of the end of the quarter. Using 2024 data, we identified that 97.18 percent of all MDS assessments were submitted to CMS within a 45-day timeframe. Of the remaining 2.82 percent submitted beyond 45 days, 0.13 percent were submitted after the current 4.5-month data submission deadline and would not be further impacted by a change in the data submission deadline. Therefore, only 2.69 percent of MDS assessments would be impacted by changing the data submission deadline from 4.5 months to require data submission by the 15th day of the second month after the end of the calendar quarter.

c. Proposal To Revise the CDC NHSN Data Submission Deadlines

Beginning with the FY 2029 SNF QRP, we are proposing that SNFs must complete their data submissions and make corrections to their CDC NHSN data where necessary no later than the 15th day of the second month after the end of the calendar quarter. However, if the 15th day of the second month falls on a Friday, weekend, or Federal holiday, the date is delayed until 11:59 p.m. EST on the next business day. We are proposing that SNFs would follow the deadlines presented in Table 14 for the FY 2029 SNF QRP. We are also proposing that similar calendar year data submission deadlines would apply to future years' payment determinations.

TABLE 14—PROPOSED DATA COLLECTION TIMEFRAME AND DATA SUBMISSION DEADLINES FOR CDC NHSN SNF QRP MEASURES AFFECTING THE FY 2029 PAYMENT DETERMINATION

Measure	Data collection timeframe	Final data submission deadlines for FY 2029 payment determination *
COVID–19 Vaccination Coverage among HCP **	January 1–March 31, 2027	May 17, 2027.
	April 1–June 30, 2027	August 16, 2027.
	July 1–September 30, 2027	November 15, 2027.
	October 1–December 31, 2027	February 15, 2028.
Influenza Vaccination Coverage among HCP	October 1, 2027–March 31, 2028	May 15, 2028.

* Data submission deadlines will follow a similar quarterly schedule for subsequent CYs.
** In section VI.C. of this proposed rule, we are proposing to remove this measure effective with the FY 2028 SNF QRP.

We believe that requiring SNFs to submit CDC NHSN data by the 15th day of the second month after the end of the calendar quarter is a reasonable timeframe to submit one week of data per month to the CDC NHSN to meet the data submission requirements of the HCP COVID–19 Vaccine measure. We note that there would be no change in the data submission deadline for the Influenza Vaccination Coverage among HCP measure, as the previously finalized data submission date is May 15th for each influenza season.

We conducted an analysis on the potential impact of reducing the timeframe by determining how many SNFs are currently reporting data by this deadline, which is approximately within 45 days of the end of the quarter. Using FY 2025 data, we identified that 95 percent of all SNFs submitted CDC NHSN data within a 45-day timeframe. On these bases, we believe revising the SNF QRP data submission deadline for MDS and CDC NHSN data to require SNFs to submit CDC NHSN data by the 15th day of the second month after the end of the calendar quarter would improve the timeliness of public reporting by 3 months, which is beneficial to both consumers and SNFs, with no change in burden to SNFs.

We invite comment on this proposal to require that SNFs complete their data submissions and make corrections to their MDS assessment data and CDC NHSN data where necessary no later than the 15th day of the second month after the end of the calendar quarter beginning with the FY 2029 SNF QRP.

3. Proposal To Require MDS Data Submission on All SNF Residents Beginning With the FY 2031 SNF QRP

a. Background

For over a decade, spanning the implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185) and the subsequent development of quality, resource use, and other measures and standardized patient assessments in accordance with the applicable statutory authority, interested parties have provided their input on and support for the need to standardize data collection across all payers in PAC settings.[16] This includes input that the quality measures used in the SNF QRP should be calculated using data collected from all SNF residents, regardless of a resident's payer, and that such data collection and submission is feasible in the SNF setting.[17] [18] Additionally, we received feedback on this topic in response to a Request for Information (RFI) in the FY 2018 SNF PPS final rule (82 FR 36603 and 36604) and a proposal in the FY 2020 SNF PPS final rule (84 FR 38817 through 38819).

In the FY 2018 SNF PPS proposed rule (82 FR 21077), we issued an RFI on expanding the collection and submission of SNF MDS data to include all SNF residents, regardless of payer, and we received overwhelming support. Responding to our RFI in the FY 2018 SNF PPS proposed rule, the Medicare Payment Advisory Commission (MedPAC) and other commenters highlighted that such data would serve to better inform beneficiaries on the broader quality of care within a SNF, especially regarding those who are or will become long-term residents of the same facility. Other commenters suggested it could support SNFs' comprehensive quality improvement efforts across payers. Furthermore, MedPAC added that while all data collection activity incurs some cost, their work has found that some SNFs already routinely assess all SNF residents regardless of payer because they feel that sorting which residents require assessments is almost as much work as completing the assessment. Additional commenters echoed MedPAC and added that collecting and submitting MDS data on all payers would be easier than having to determine which residents were Medicare fee-for-service (FFS). For a more detailed discussion of these comments, we refer readers to the FY 2018 SNF PPS final rule (82 FR 36603 and 36604).

In the FY 2020 SNF PPS proposed rule (84 FR 17678 and 17679), we proposed to expand the collection and submission of MDS data to all SNF residents regardless of payer for purposes of the SNF QRP. Although we decided not to finalize the proposal in the FY 2020 SNF PPS final rule (84 FR 38817 through 38819), we did receive comments from several commenters who supported aligning data collection and submission under the SNF QRP with the practices of other quality programs. These commenters noted that our proposal would give consumers a more complete picture of quality within a SNF and that ensuring quality of care is essential to the overall well-being of all SNF residents and should not be conditional on the payer source. However, other commenters did not support the proposal and expressed concern about the lack of details found in the proposal, including which residents would be captured under an expanded SNF MDS data collection and submission policy, the intended use of the data, and how this proposal would affect penalties for non-compliance in the SNF QRP. Commenters were also concerned about the reporting burden associated with expanding MDS data collection and submission and whether the data would be publicly reported. As noted previously, we did not finalize the proposal at the time but stated that we would use the input we received to revise our policy and propose it in future rulemaking. For a more detailed discussion of these comments and our decision to not finalize this proposal, we refer readers to the FY 2020 SNF PPS final rule (84 FR 38817 through 38819).

Since 2019, we have worked to address this feedback in anticipation of a future proposal. Our work included gathering additional feedback from interested parties on specific questions related to implementing a policy to expand data submission for the SNF QRP during two national SNF Listening Sessions hosted by our contractor in 2023 [19] and 2024.[20] During both listening sessions, we heard from SNFs that submitting data on all SNF residents is feasible, and that some SNFs currently collect MDS data on all residents, regardless of payer.

b. Support for Expanding MDS Data Submission on All SNF Residents Regardless of Payer

The concept of requiring data submission on all patients/residents regardless of payer is not new. We currently require data submission on all patients regardless of payer as part of the Inpatient Rehabilitation Facility (IRF) QRP, the Long-Term Care Hospital (LTCH) QRP, the Home Health (HH) QRP, and the Hospice QRP (HQRP). Eligible clinicians participating in the Merit-based Incentive Payment System (MIPS) who submit quality measure data on Qualified Clinical Data Registry (QCDR) measures, MIPS clinical quality measures (CQMs), or electronic clinical quality measures (eCQMs) must submit such data on a specified percentage of patients regardless of payer. Submitting such data on all SNF residents, regardless of payer, in the SNF setting would align the SNF QRP with the data submission practices of other CMS programs.

Until SNFs adopt a policy to submit MDS data on all SNF residents regardless of payer, the SNF QRP risks losing relevance to the SNF community and SNF consumers. According to the Congressional Budget Office (CBO), total Medicare Advantage enrollment in 2025 was estimated to be 54 percent of all beneficiaries and by 2034, the number is expected to rise to 64 percent of all beneficiaries.[21] As a result, if any of those beneficiaries require SNF services, they would not be included in the SNF QRP since the program currently requires MDS data submission only for Medicare FFS residents. Therefore, submitting MDS data on all SNF residents, regardless of payer, would

[16] MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement. Feb 2012. Available at *https://digitalassets.jointcommission.org/api/public/content/0309517406bf4b87972b9a433a689c87?v=0fa83028*.

[17] Public Comment Summary Report Posting for Transfer of Health Information and Care Preferences. Available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-of-Cross-Setting-Transfer-of-Health-Information-Quality-Meas.pdf*.

[18] Technical Expert Panel Summary Report: Development and Maintenance of Quality Measures for Skilled Nursing Facility Quality Reporting Program. April 2018. Available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/TEP-Summary-Report_April-2018_Development-and-Maintenance-of-Quality-Measures-for-SNF-QRP.pdf*.

[19] Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Summary Report. August 29, 2023. Available at *https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf*.

[20] Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Summary Report. October 1, 2024. Available at *https://www.cms.gov/files/document/snfallpayerlisteningsession2024summaryreportv3508.pdf*.

[21] Ochieng, N., Freed, M., Biniek, J.F., Damico, A. Neuman, T. Medicare Advantage in 2025: Enrollment Update and Key Trends. Kaiser Family Foundation. Published July 28, 2025. Accessed November 14, 2025. Available at *https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/*.

provide the most robust and accurate representation of SNF quality.

In addition to aligning the SNF QRP with the data submission practices of other CMS programs and providing the most robust and accurate representation of SNF quality, we believe that submitting data using the MDS should include all SNF residents regardless of payer for other reasons. For instance, requiring submission of MDS data on all SNF residents, regardless of payer, could promote higher quality more efficient healthcare for all residents through standardization of data submission and support for the exchange of longitudinal information between SNFs and other providers. This information exchange could facilitate coordinated care, continuity in care planning, and the discharge planning process. Furthermore, expanding data collection to all SNF residents regardless of payer could support SNFs in their quality improvement activities.[22] Finally, adopting this policy could contribute to better healthcare outcomes for our beneficiaries, enabling them to make more informed decisions about where to receive SNF care.[23] [24] As stated previously, unless we adopt a policy to expand data submission to all SNF residents regardless of payer, SNFs will continue to lag behind other PAC settings who already submit this assessment information on all patients. However, we note that we would not use these data from non-Medicare FFS residents to update the payment rates used under the SNF PPS.

c. Considerations for Expansion of MDS Data Submission to All SNF Residents

As previously noted in section VI.F.3.a. of this proposed rule, we received several constructive comments when we proposed to expand the submission of MDS data in the FY 2020 SNF PPS proposed rule. We have used these comments to inform our proposals for the form, time, and manner of MDS data submission on all SNF residents regardless of payer in the FY 2027 SNF PPS proposed rule.

Implementation of a policy requiring MDS data submission on all SNF residents regardless of payer presents unique considerations for CMS that have not been encountered in other settings because the MDS data are required for reasons other than quality reporting and Medicare payment. One consideration is the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 100–203) that requires nursing homes that are Medicare certified, Medicaid certified or both, conduct initial and periodic MDS assessments for both long-term residents and short-term residents in a rehabilitative program anticipating return to their previous environment or another environment of their choice. Another consideration is that data submitted in MDS assessments are used by many state Medicaid payment and quality programs. These considerations informed our proposals for the policies discussed next.

(1) Defining Skilled Services

In response to our FY 2020 SNF PPS proposal to expand SNF MDS data submission to all SNF residents regardless of payer, we heard from commenters that they needed to know how to identify the resident population for whom they would be required to submit MDS data under an expanded policy. Specifically, we received several questions about how ''skilled services'' would be defined for non-Medicare Part A FFS residents receiving skilled care (84 FR 17678 and 17679).

We define a skilled nursing facility level of care under the Medicare Part A benefit in the Medicare Benefit Policy Manual (MBPM) (100–2), Chapter 8, § 30.[25] Care in a SNF is covered by the Medicare Part A benefit when the following four factors listed are listed are met:

- The patient requires skilled nursing services or skilled rehabilitation services, that is, services that must be performed by or under the supervision of professional or technical personnel (see MBPM §§ 30.2 through 30.4); are ordered by a physician and the services are rendered for a condition for which the beneficiary received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services.
- The patient requires these skilled services on a daily basis (see MBPM § 30.6).
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See MBPM § 30.7)
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, that is, are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

SNFs should be familiar with this definition since they use it daily to make decisions about whether a Medicare Part A resident qualifies for a covered SNF level of care.

We presented this definition to interested parties attending the August 2023 SNF Listening Session: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer.[26] We sought feedback about using this definition to identify SNF residents, regardless of payer, requiring an MDS assessment for purposes of submitting data. Participants of the 2023 SNF Listening Session generally supported the idea of a standardized definition of skilled services across all payers and stated that it would be feasible to use a modified definition of skilled services as described in the Medicare Benefits Policy Manual (Chapter 8, § 30) to identify residents for the purposes of MDS data submission.

We are not proposing to change the coverage criteria for a Medicare Part A FFS covered stay. However, given the SNFs' familiarity with the definition of covered skilled services in the Medicare Benefits Policy Manual, we believe a modified version of Chapter 8, § 30 will work for determining whether an expanded resident population meets a skilled nursing facility level of care.

Therefore, we are proposing that SNFs would submit MDS data on all SNF residents regardless of payer when all of the following four criteria are met:

- When the resident is admitted to the SNF for covered skilled nursing services or skilled rehabilitation services, that is, services that must be performed by or under the supervision of professional or technical personnel (see MBPM §§ 30.2 through 30.4) and those services are ordered by a physician.
- The resident requires these skilled services on a daily basis (see MBPM § 30.6).

[22] CMS National Quality Strategy. Accessed November 14, 2025. Available at *https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy.*

[23] Ibid.

[24] Report to Congress: Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 Strategic Plan for Accessing Race and Ethnicity Data. January 5, 2017. Accessed November 26, 2024. Available at *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Research-Reports-2017-Report-to-Congress-IMPACT-ACT-of-2014.pdf.*

[25] Medicare Benefits Policy Manual (100–2), Chapter 8. Available at *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf.*

[26] Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Summary Report. August 29, 2023. Available at *https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf.*

• As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF (see MBPM § 30.7).

• The services delivered are reasonable and necessary for the treatment of a resident's illness or injury, that is, are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice, and are reasonable in terms of duration and quantity.

(2) Identifying the Resident Population for the Submission of MDS Data

SNFs are distinct from the IRF and LTCH settings, which only provide services to patients for limited periods of time and, in the case of IRFs, for certain medical conditions. In 2025, 95 percent of all SNFs were also certified under Medicaid as nursing facilities (NFs).[27] These dually certified SNFs/NFs are long-term care facilities that furnish care continuously to both Medicare and Medicaid beneficiaries in the nursing home, which is their place of residence. The SNF QRP applies to freestanding SNFs, including dually certified SNFs/NFs, SNFs affiliated with acute care facilities, and all non-critical access hospital (CAH) swing bed rural hospitals. As such, our proposal would cover the resident populations of these facilities. For ease of reference, we will hereafter refer to these entities collectively as SNFs.

As noted previously, since residents can be admitted to a SNF for different reasons, such as short-term skilled care, or long-term services and supports for limitations in activities of daily living and instrumental activities of daily living, it is important that we further define the resident population for expanding the submission of MDS data.

Long-term residents in SNFs may experience changes in the level of care they require without leaving the facility. Specifically, a long-term resident's level of care may change from non-skilled to skilled without a hospitalization. Over the last several years, SNF care has evolved in response to internal and external factors, including increased clinical specialization of SNFs, an increasing number of beneficiaries choosing MA benefits and the competition among SNFs to be an 'in-network provider,' an increased number of and attention to resource use measures in the SNF QRP and VBP, and the COVID–19 public health emergency (PHE). Increasingly, it is common practice for SNFs to ''skill-in-place'' their long-term residents who several years ago may have been immediately sent to the emergency department for evaluation. When a long-term resident is ''skilled-in-place'', the SNF provides skilled services to address a long-term resident's change in condition to prevent or in lieu of a hospital admission.

Furthermore, MA organizations may authorize coverage of SNF care in the absence of a prior qualifying hospital stay. This includes long-term residents who may be enrolled in a Special Needs Plan (SNP) [28] or may have other commercial insurances or long-term care policies that are covering their skilled care.

Therefore, expansion of a policy to include the submission of MDS data must address whether all residents receiving skilled services in a facility would be included in the policy. This could include being admitted after an inpatient stay for short term skilled services, or a long-term resident who develops a need for skilled services and receives them without being discharged to the hospital. We also heard from participants in both the 2023 and 2024 SNF Listening Sessions that identifying changes in level of care across different payers and resident types would be challenging and burdensome. Specifically, we heard in the 2024 SNF Listening Session that trying to manage a same day change in a long-term resident's need for skilled services would be difficult and add confusion to the process of determining which assessments would be required given the complexity of balancing SNF MDS assessments and MDS OBRA requirements.

In response to these concerns, we are proposing to require submission of MDS data on residents admitted or readmitted for covered skilled services regardless of payer, rather than any long-term resident residing in the facility who becomes skilled in place, that is requiring skilled services without leaving the facility. We are also proposing that long-term residents who take a leave of absence [29] and return to the facility requiring skilled care would not require a skilled care admission assessment and submission of MDS data, while long-term residents that are discharged from the facility,[30] and are subsequently readmitted for covered skilled care would trigger the submission of MDS data. We note, however, that under this proposal, we would not require the submission of MDS data if the services were not covered. Additionally, a short-term resident who was admitted for covered skilled care, who left the facility for any reason and returned to the same SNF requiring skilled services before the end of the interruption window,[31] would not require a new MDS assessment as long as their services remained skilled and were covered. Instead, their subsequent stay is considered a continuation of the previous skilled care stay for purposes of the SNF QRP.

We believe that limiting the submission of MDS data to residents admitted or readmitted to the SNF for covered skilled services would align the SNF QRP population with other PAC QRPs, and meet the goal of obtaining full and complete data regarding the quality of care provided by the SNF to the residents receiving care in that facility.

Finally, while we appreciate that submitting MDS data on all SNF residents regardless of payer may create additional burden, we also note that this burden may be partially offset by the fact that SNFs would no longer have to determine which residents admitted or readmitted for covered skilled services require MDS data submission. We have also learned that many SNFs already collect MDS data on non-Medicare FFS residents but do not submit it.[32] [33] We

[27] Distribution of Certified Nursing Facilities by Certification Type | KFF State Health Facts. July 2025. Available at *https://www.kff.org/other-health/state-indicator/nursing-facilities-by-certification-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

[28] Special Needs Plans | CMS. September 10, 2024. Available at *https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans.*

[29] A leave of absence occurs when a resident has a: temporary home visit of at least one night; or therapeutic leave of at least one night; or hospital observation stay less than 24 hours and the hospital does not admit the resident.

[30] A discharge occurs when: Resident is discharged from the facility to a private residence (as opposed to going on an LOA); Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record); Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident. Resident is transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed. Resident's covered skilled stay ends, but the resident remains in the facility.

[31] An interruption window occurs when a resident leaves the facility for a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days.

[32] Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Summary Report. August 29, 2023. Available at *https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf.*

[33] Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Summary Report. October 1, 2024. Available

Continued

also acknowledge past concerns raised by some interested parties with respect to the administrative challenges of implementing all payer data submission and the need to account for the burden related to the proposal. In section VIII.B. of the proposed rule, we provide an estimate of additional burden related to the proposal.

d. Proposal To Require MDS Data Submission on All SNF Residents Regardless of Payer for the SNF QRP

We are proposing to require the submission of MDS data on each resident receiving covered skilled care in a SNF, regardless of payer, beginning with the FY 2031 SNF QRP. Specifically, we are proposing that SNFs would be required to submit these data for all SNF residents, regardless of payer, beginning with residents admitted on October 1, 2029 for purposes of the FY 2031 SNF QRP.[34] Starting in CY 2030, SNFs would be required to submit data for the entire calendar year beginning with the FY 2032 SNF QRP.

We are also proposing that SNFs would submit these data on all non-Medicare FFS SNF residents at admission and discharge using the Nursing Home PPS (NP) and the Nursing Home Part A PPS Discharge (NPE) assessments and the corresponding Swing Bed assessments (SP and SD) in use at the time of data collection. Based on feedback shared by the SNFs during listening sessions, we believe many SNFs already collect MDS data on non-Medicare FFS residents but do not submit it.

In order to facilitate the collection of this new data, we would revise the current MDS for SNFs to submit data pursuant to the proposed policy. Specifically, we would modify one item and add three new items to the MDS. One item in the Type of Assessment section would be modified to indicate when an assessment is being completed at admission for a non-Medicare FFS resident receiving covered skilled services. The first new item would collect information on the resident's primary payer for the skilled stay at admission, and at discharge from covered skilled services. A second new item would capture the start and end dates of a covered skilled stay for a non-Medicare-FFS resident. Finally, a third new item would be added to the Type of Assessment section to indicate whether the assessment is being completed for a non-Medicare FFS resident at the time of discharge from covered skilled services. A draft of the proposed modified and new items can be found in the Downloads section of the SNF QRP Measures and Technical Information web page at *https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information.*

Furthermore, the Secretary must reduce the annual payment update applicable to a SNF for a fiscal year by 2 percentage points if the SNF does not submit data in accordance with the SNF QRP requirements established by the Secretary. As set forth in our regulations at 42 CFR 413.360(f)(1)(ii), 90 percent of the MDS assessments SNFs submitted through the CMS designated data system must contain 100 percent of the required data. Therefore, we are proposing that the MDS data SNFs submit under this proposal for all SNF residents, regardless of payer, would be used to calculate SNF QRP compliance. The SNF QRP also requires the data be submitted to CMS according to the established data submission deadlines. The current SNF QRP data submission deadline for MDS data is approximately 4.5 months after each quarterly data collection period. In section VI.F.2. of this proposed rule, we are proposing to revise the data submission deadline from 4.5 months to the 15th day of the second month after the end of the calendar quarter, which would have implications for this proposal if finalized.

Finally, we want to clarify that, while expanding the submission of MDS data to include all SNF residents admitted or readmitted for skilled covered care regardless of payer would permit the SNF QRP to make publicly available information regarding the quality of services furnished to the SNF population as a whole, we are not proposing any changes to our policies related to publicly reporting SNF QRP data collected on non-Medicare FFS residents at this time. We routinely monitor the SNF QRP data and any future changes related to the public reporting of the SNF QRP all payer data would be communicated through our normal communication channels.

We invite public comments on this proposal to require the submission of MDS data on all SNF residents admitted for covered skilled care regardless of payer beginning with the FY 2031 SNF QRP.

G. Policies Regarding Public Display of Measure Data for the SNF QRP

1. Background

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52045 through 52048) for a discussion of our policies regarding public display of SNF QRP measure data and procedures for SNFs to review and correct data and information prior to their publication.

2. Proposal To End the Public Display of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure

In the FY 2022 SNF PPS final rule (86 FR 42496 through 42498), we finalized our proposal to publicly report the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure (HCP COVID–19 Vaccine) beginning with the October 2022 Care Compare refresh on *Medicare.gov*. In section VI.C. of this proposed rule, we are proposing to remove the HCP COVID–19 Vaccine measure beginning with the FY 2028 SNF QRP. If finalized as proposed, a SNFs' HCP COVID–19 Vaccine measure data would be publicly reported for the last time with the October 2026 Care Compare refresh on *Medicare.gov,* based on data from Q4 of 2025. Thereafter, we would no longer display a SNF's HCP COVID–19 Vaccine measure data on the Care Compare tool at *Medicare.gov*.

We invite comment on our proposal to end public display of the HCP COVID–19 Vaccine measure data after the October 2026 Care Compare refresh on the Care Compare tool at *Medicare.gov*.

3. Proposal To End the Public Display of the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure

In the FY 2024 SNF PPS final rule (88 FR 53275 through 53276), we finalized our proposal to begin publicly displaying data for the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure (Patient/Resident COVID–19 Vaccine) beginning with the October 2025 Care Compare refresh. In section VI.D. of this proposed rule, we would remove the Patient/Resident COVID–19 Vaccine measure beginning with the FY 2028 SNF QRP. If finalized as proposed, the reporting of data for the ''Resident's COVID–19 vaccination is up to date'' data element would be voluntary effective October 1, 2026, and the Patient/Resident COVID–19 Vaccine measure data would be publicly reported for the last time with the October 2026 Care Compare refresh on *Medicare.gov,* based on data from Q4 of 2025.

at *https://www.cms.gov/files/document/snfallpayerlisteningsession2024summaryreportv3508.pdf.*

[34] There is an exemption for residents where the third-party insurer does not cover the cost of skilled services.

We invite public comment on our proposal to end the public display of Patient/Resident COVID–19 Vaccine measure data after the October 2026 Care Compare refresh on *Medicare.gov*.

VII. Updates to the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

A. Statutory Background

Through the SNF VBP Program, we award incentive payments to SNFs to encourage improvements in the quality of care provided to Medicare beneficiaries. The SNF VBP Program is authorized by section 1888(h) of the Act, and it applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-critical access hospitals (CAH) swing-bed rural hospitals. The SNF VBP Program has helped to transform how Medicare payment is made for SNF care, moving toward rewarding better value and outcomes instead of merely rewarding volume. Our codified policies for the SNF VBP Program can be found in our regulations at 42 CFR 413.337(f) and 413.338.

B. SNF VBP Program Measures

1. Background

Our current measure selection, retention, and removal policy is codified at 42 CFR 413.338(k). We also refer readers to the FY 2024 SNF PPS final rule for background on the measures we have adopted for the SNF VBP Program (88 FR 53276 through 53297). Table 15 lists the measures that have been adopted for the SNF VBP Program, along with their status in the program for the FY 2027 program year through the FY 2030 program year.

TABLE 15—SNF VBP PROGRAM MEASURES AND STATUS IN THE SNF VBP PROGRAM FOR THE FY 2027 PROGRAM YEAR THROUGH THE FY 2030 PROGRAM YEAR

Measure	FY 2027 program year	FY 2028 program year	FY 2029 program year	FY 2030 program year
Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM).	Included			
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (SNF HAI) measure.	Included	Included	Included	Included.
Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) measure.	Included	Included	Included	Included.
Total Nursing Staff Turnover (Nursing Staff Turnover) measure	Included	Included	Included	Included.
Discharge to Community—Post-Acute Care Measure for Skilled Nursing Facilities (DTC PAC SNF).	Included	Included	Included	Included.
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury (Long-Stay)) measure.	Included	Included	Included	Included.
Discharge Function Score for SNFs (DC Function) measure	Included	Included	Included	Included.
Number of Hospitalizations per 1,000 Long Stay Resident Days (Long Stay Hospitalization) measure.	Included	Included	Included	Included.
Skilled Nursing Facility Within-Stay Potentially Preventable Readmissions (SNF WS PPR) measure.		Included	Included	Included.

2. Proposed Regulation Text Technical Update

We are proposing to update a reference within our codified measure selection, retention, and removal policy that we finalized in the FY 2025 SNF PPS final rule (89 FR 64126 through 64127) but did not update when finalizing other updates to the regulations in the FY 2026 SNF PPS final rule (90 FR 37345 through 37352). Specifically, we are proposing to update 42 CFR 413.338(k)(3) to reference § 413.338(k)(2) of the regulations for details on the measure selection, retention, and removal policy rather than § 413.338(l)(2).

We welcome public comment on this proposed technical update to our regulation text.

C. SNF VBP Performance Standards

1. Background

Our current definitions for the performance standards are codified at 42 CFR 413.338(a), and our current performance standards notification and updates policies are codified at 42 CFR 413.338(m). We also refer readers to the FY 2024 SNF PPS final rule (88 FR 53299 through 53300) for a detailed history of our performance standards policies. In the FY 2026 SNF PPS final rule (90 FR 37348 through 37349), we adopted the final numerical performance standards for the remaining measures applicable to the FY 2028 program year, and the final numerical performance standards for the FY 2029 program year for the Discharge to Community—Post-Acute Care Measure for Skilled Nursing Facilities (DTC PAC SNF) and Skilled Nursing Facility Within-Stay Potentially Preventable Readmissions (SNF WS PPR) measures.

2. Estimated Performance Standards for the FY 2029 Program Year

To meet the requirements at section 1888(h)(3)(C) of the Act, we are providing estimated numerical performance standards for the remaining measures applicable to the FY 2029 program year: the SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI) measure, Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) measure, Total Nursing Staff Turnover (Nursing Staff Turnover) measure, Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury (Long-Stay)) measure, Number of Hospitalizations per 1,000 Long Stay Resident Days (Long Stay Hospitalization) measure, and Discharge Function Score for SNFs (DC Function) measure. In accordance with our methodology for calculating performance standards previously finalized in the FY 2017 SNF PPS final rule (81 FR 51996 through 51998), the estimated numerical values for the FY 2029 program year performance standards are shown in Table 16. We will provide the final numerical performance standards for these measures for the FY 2029 program year in the FY 2027 SNF PPS final rule.

TABLE 16—ESTIMATED FY 2029 SNF VBP PROGRAM PERFORMANCE STANDARDS

Measure short name	Achievement threshold	Benchmark
SNF HAI Measure	0.92183	0.94491
Total Nurse Staffing Measure	3.29119	5.87448
Nursing Staff Turnover Measure	0.42696	0.76652
Falls with Major Injury (Long-Stay) Measure	0.95455	0.99951
Long Stay Hospitalization Measure	0.99768	0.99963
DC Function Measure	0.41935	0.80879

3. Estimated Performance Standards for the FY 2030 Program Year

To meet the requirements at section 1888(h)(3)(C) of the Act, we are providing estimated numerical performance standards for the FY 2030 program year for the DTC PAC SNF and SNF WS PPR measures. In accordance with our methodology for calculating performance standards previously finalized in the FY 2017 SNF PPS final rule (81 FR 51996 through 51998), the estimated numerical values for the FY 2030 program year performance standards for the DTC PAC SNF and SNF WS PPR measures are shown in Table 17. We will provide the final numerical performance standards for these two measures for the FY 2030 program year in the FY 2027 SNF PPS final rule.

We will provide the estimated numerical performance standards values for the remaining measures applicable to the FY 2030 program year in the FY 2028 SNF PPS proposed rule.

TABLE 17—ESTIMATED FY 2030 SNF VBP PROGRAM PERFORMANCE STANDARDS

Measure short name	Achievement threshold	Benchmark
DTC PAC SNF Measure	0.43478	0.68049
SNF WS PPR Measure	0.86219	0.92400

D. Proposed Updates to the SNF VBP Review and Correction Process

1. Background

We refer readers to the FY 2026 SNF PPS final rule (90 FR 37350 through 37352) and to 42 CFR 413.338(f) for details on the SNF VBP Program's confidential feedback reports policies, the two-phase review and correction process, the reconsideration process, and public reporting policies that we have adopted for the Program. We also refer readers to the SNF VBP Program website (*https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/confidential-feedback-reporting-review-and-corrections*) for technical details on our review and correction process and reconsideration process.

In Phase One of the review and correction process, codified at 42 CFR 413.338(f)(2), we accept correction requests for 30 days after distributing the baseline period and performance period quality measure quarterly reports, which contain the baseline period and performance period measure results, respectively. SNFs may submit requests for corrections to the measure results contained in those reports. The underlying data used to calculate the measure results are not subject to review and correction during this process. As provided in 42 CFR 413.338(f)(1), measure results included in those reports are calculated using data current as of specified dates for each measure. These specified dates are referred to as ''snapshot dates.'' If a SNF desires to correct their underlying data used to calculate a particular measure result, the underlying data must be corrected by the specified snapshot date to confirm the correction will be reflected in the SNF VBP Program's quarterly confidential feedback reports.

In Phase Two of the review and correction process, codified at 42 CFR 413.338(f)(3), we accept correction requests for 30 days after distributing the Performance Score Report, which contains the SNF performance score and ranking. SNFs may submit requests for corrections to the SNF performance score and ranking contained in this report.

Under our review and correction policy, the SNF must identify the error for which it is requesting correction, explain its reason for requesting the correction, and submit documentation or other evidence, if available, supporting the request. As provided in 42 CFR 413.338(f)(2) and (f)(3), correction requests must contain all of the following:

- The SNF's CMS Certification Number (CCN).
- The SNF's name.
- The correction requested.
- The reason for requesting the correction, including any available evidence to support the request.

We review all review and correction requests and notify the requesting SNF of our decision. We also implement any approved corrections before the affected data becomes publicly available on the website CMS uses to make quality data available to the public, currently the Provider Data Catalog website (*https://data.cms.gov/provider-data/*).

In the reconsideration process, codified at 42 CFR 413.338(f)(6), we allow SNFs to seek reconsideration of a valid review and correction request if they are not satisfied with our decision on the review and correction request submitted under 42 CFR 413.338(f)(2) or (f)(3). We accept reconsideration requests for 15 days, starting the day after the date we issue a decision via email on the review and correction request (as noted on that decision). As provided in 42 CFR 413.338(f)(6), SNFs that seek reconsideration of a review and correction request decision have to submit their reconsideration requests via email in the form and manner specified by CMS in the review and correction decision, and the reconsideration request has to contain all of the following:

- The SNF's CMS Certification Number (CCN).
- The SNF's name.
- The issue for which the SNF submitted a review and correction request, received a review and correction request decision, and are requesting reconsideration of.
- The reason why the SNF is requesting reconsideration, which can be supported by any applicable documentation or other evidence.

We review all reconsideration requests and provide a written decision to the SNF in a timely manner before any affected data becomes publicly available on the website CMS uses to make quality data available to the public, currently the Provider Data Catalog website (*https://data.cms.gov/provider-data/*).

In this proposed rule, we are proposing to update the ''snapshot dates'' codified at 42 CFR 413.338(f)(1)(v) for two MDS-based measures, beginning with FY 2027 data, to maintain alignment with the proposed revisions to SNF QRP submission deadlines for MDS assessment data included in section VI.X. of this proposed rule.

2. Proposal To Update ''Snapshot Dates'' for the SNF VBP Program's MDS-Based Measures

In the FY 2024 SNF PPS final rule (88 FR 53286 through 53293), we adopted the Falls with Major Injury (Long-Stay) and DC Function measures, both beginning with the FY 2027 SNF VBP program year. These two measures are calculated using assessment data reported by SNFs on the MDS 3.0.

In the FY 2025 SNF PPS final rule (89 FR 64136), we finalized application of the existing Phase One review and correction process to SNF VBP Program measures calculated using MDS data. That is, SNFs may submit requests for corrections to the measure results for the MDS-based measures adopted by the SNF VBP Program during Phase One of the review and correction process. We also adopted ''snapshot dates'' for the Falls with Major Injury (Long-Stay) and DC Function measures, the current two MDS-based measures adopted by the SNF VBP Program. For corrections to the underlying MDS assessment data to be reflected in the SNF VBP Program's quarterly confidential feedback reports, a SNF must make any corrections to the underlying data via the internet Quality Improvement Evaluation System (iQIES) before the ''snapshot date,'' and we finalized that the ''snapshot date'' is the February 15th that is 4.5 months after the last day of the applicable baseline or performance period. However, if February 15th falls on a Friday, weekend, or Federal holiday, the data submission deadline is delayed until 11:59 p.m. EST on the next business day. For example, for the FY 2027 SNF VBP program year, the performance period is FY 2025 (October 1, 2024, through September 30, 2025). The ''snapshot date'' for this performance period would normally be February 15, 2026. However, since February 15, 2026, falls on a Sunday, the snapshot date was extended until the next business day, which is Tuesday, February 17, 2026, due to Monday, February 16, 2026, being a Federal holiday. This is consistent with the SNF QRP QM User's Manual available at *https://www.cms.gov/files/document/snf-qm-calculations-and-reporting-users-manual-v70.pdf*.

However, in the FY 2026 SNF PPS final rule (90 FR 37342 through 37343), we included a Request for Information (RFI) regarding shortening the SNF QRP's MDS assessment data submission deadline from 4.5 months to 45 days to improve the timeliness of measure calculations and public reporting. Many commenters noted their support for such a change, as timely reporting would be valuable for consumers, professionals, and facilities, and in section VI.X. of this proposed rule, we are proposing to update the MDS assessment data submission deadline from 4.5 months to the 15th day of the second month after the end of each calendar quarter, beginning with CY 2027 data, to expedite the reporting of MDS assessment data via iQIES. As discussed in section VI.X. of this proposed rule, this expedited deadline will improve the timeliness of public reporting by 3 months, which is beneficial to both consumers and SNFs, with minimal impact on data completeness, as the vast majority of SNFs submit their MDS assessment data within 45 days.

To maintain alignment with the proposed revisions to the SNF QRP's submission deadline for MDS assessment data, we propose to update the ''snapshot date'' definition for the DC Function and Falls with Major Injury (Long-Stay) measures beginning with data collected in FY 2027. We propose to redefine the ''snapshot date'' as the 15th day of the second month after the last day of the applicable baseline or performance period. However, if the 15th day of the second month after the last day of the applicable baseline or performance period falls on a Friday, weekend, or Federal holiday, the snapshot date is delayed until 11:59 p.m. EST on the next business day. We expect this revision will be consistent with the updated SNF QRP QM User's Manual, to be published prior to the start of CY 2027.

We also propose to codify this proposed revision to the ''snapshot date'' for the DC Function and Falls with Major Injury (Long-Stay) measures by updating 42 CFR 413.338(f)(1)(v). We invite public comment on our proposals.

E. SNF VBP Extraordinary Circumstances Exception Policy

1. Background

We refer readers to 42 CFR 413.338(l) for details on the SNF VBP Program's Extraordinary Circumstances Exception (ECE) policy. The ECE policy allows SNFs to request an exception to the SNF VBP Program's requirements for one or more calendar months if the SNF is able to demonstrate that an extraordinary circumstance beyond the control of the SNF affected the care provided to its residents, and subsequent measure performance, or affected the SNF's ability to report SNF VBP data on one or more measures by the specified deadline.

SNFs must submit an ECE request within 90 days of the date that the extraordinary circumstance occurred.

We review exception requests, and at our discretion, based on our evaluation of the impact of the extraordinary circumstance on the SNF's care and/or its ability to report data, CMS will respond to the SNF with a decision as quickly as is feasible.

If we approve a SNF's ECE request, we exclude the SNF's underlying data for the calendar months during which the SNF was affected by the extraordinary circumstance from the SNF VBP Program's measure calculations, and calculate a SNF performance score for the program year that does not include the SNF's performance on the measure or measures during the months the SNF was affected by the extraordinary circumstance.

2. Proposed Regulation Text Technical Updates

We are proposing to update certain references within our codified Extraordinary Circumstances Exception (ECE) policy that we finalized in the FY 2025 SNF PPS final rule (89 FR 64136 through 64137) but did not update when finalizing other updates to the regulations in the FY 2026 SNF PPS final rule (90 FR 37345 through 37352). Specifically, we are proposing to update 42 CFR 413.338(l)(3) to reference 42 CFR 413.338(l)(4) and (2) of the regulations for details on the ECE policy rather than 42 CFR 413.338(m)(4) and (2).

We welcome public comment on these proposed technical updates to our regulation text.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501 through 3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the

affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

Using the following format describe the information collection requirements that are in each section.

A. ICRs Regarding the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

With regard to the SNF VBP Program, in section VII.X. of this proposed rule, we are proposing to update the ''snapshot date'' codified at 42 CFR 413.338(f)(1)(v) for two measures that are calculated using MDS assessment data to maintain alignment with proposed SNF QRP submission deadlines for MDS assessment data, beginning with FY 2027 data. The ''snapshot date'' is utilized by the existing review and correction process, which provides SNFs an opportunity to review information that is to be made public with respect to the facility prior to such information being made public, as required by section 1888(g)(6)(B) of the Act. This opportunity to review is exempt from the Paperwork Reduction Act, as specified by section 1888(g)(7) of the Act. This opportunity to review information during the review and correction process is also voluntary, and the proposed modifications to the ''snapshot date'' will not create any new, required reporting burdens for SNFs.

Because this rule does not propose removing or adding any new or revised collection of information requirements or burden specific to the SNF VBP Program, this section of the rule is not subject to OMB approval under the authority of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*). For the purpose of this section, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

B. ICRs Regarding the Skilled Nursing Facility Quality Reporting Program (SNF QRP)

In accordance with section 1888(e)(6)(A)(i) of the Act, the Secretary must reduce by 2-percentage points the otherwise applicable annual payment update to a SNF for a fiscal year if the SNF does not comply with the requirements of the SNF QRP for that fiscal year.

As stated in section VI.F.2. of this proposed rule, we are proposing to revise the SNF QRP assessment data submission deadline to no later than the 15th day of the second month after the end of each calendar quarter beginning with the FY 2029 SNF QRP. If finalized, this requirement would not result in additional burden for the SNF QRP.

1. Wage Estimates

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages from the U.S. Bureau of Labor Statistics' (BLS) May 2024 National Occupational Employment and Wage Estimates.[35] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 18.

TABLE 18—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2024 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Administrative Assistants	43–6013	$21.91	$21.91	$43.82
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29–2061	30.84	30.84	61.68
Occupational Therapy (OT)	29–1122	47.23	47.23	94.46
Physical Therapy (PT)	29–1123	49.23	49.23	98.46
Registered Nurse (RN)	29–1141	47.32	47.32	94.64
Speech-Language Pathologist (SLP)	29–1127	46.08	46.08	92.16

2. ICRs for Proposed Measure Removal Updates Related to the SNF QRP Beginning With the FY 2028 SNF QRP

In section VI.C. of the proposed rule, we are proposing to remove the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) (HCP COVID–19 Vaccine) measure. We are also proposing, in section VI.D. of this propose rule, to remove the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure. If these proposals are finalized, both measure removals will be effective beginning with the FY 2028 SNF QRP.

a. ICRs for Proposed Removal of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning With the FY 2028 SNF QRP

In section VI.C. of the proposed rule, we are proposing to remove the HCP COVID–19 Vaccine measure, beginning with the FY 2028 SNF QRP. We note that the CDC would account for the burden associated with the HCP COVID–19 Vaccine measure collection under OMB control number 0920–1317 (expiration 01/31/2028). Currently, the CDC does not estimate burden for COVID–19 vaccination reporting under the CDC PRA package approved under OMB control number 0920–1317 because the agency has been granted a waiver under section 321 of the National Childhood Vaccine Injury Act of 1986 (Pub. L. 99–660, enacted on November 14, 1986 (NCVIA)).[36] However, CMS is providing an estimate of the reduction in burden and cost for SNFs here. Consistent with the CDC's experience of collecting data using the NHSN, we estimate the removal of this measure will result in a reduction of 1 hour(s) per month to collect data for the HCP COVID–19 Vaccine measure and enter it into NHSN. We believe that this

[35] U.S. Bureau of Labor Statistics' (BLS) May 2024 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

[36] Section 321 of the NCVIA provides the PRA waiver for activities that come under the NCVIA, including those in the NCVIA at section 2102 of the Public Health Service Act (*https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap6A-subchapXIX-part1-sec300aa-2.pdf*). Section 321 is not codified in the U.S. Code but can be found in a note *(https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap6A-subchapXIX-part1-sec300aa-1.pdf*).

data would be entered by an administrative assistant. However, SNFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2024 National Occupational Employment and Wage Estimates.[37] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 18.

We estimate that the removal of the HCP COVID–19 measure from the SNF QRP will result in a reduction of 12.00 hours per SNF per year. Using FY 2025 data, we estimate an annual decrease of 178,416.00 hours (12.00 hours × 14,868 SNFs) for all SNFs. Given an estimated $43.82 hourly wage for administrative assistants, we estimate a decrease of $525.84 per SNF (12 hours × $43.82), or an annual decrease of $7,818,189.12 for all SNFs ($525.84 × 14,868 SNFs). The total estimated annual cost decrease is summarized in Table 19.

TABLE 19—ESTIMATED BURDEN REDUCTION ASSOCIATED WITH REMOVAL OF THE HCP COVID–19 VACCINE MEASURE BEGINNING WITH THE FY 2028 SNF QRP

Requirement	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Proposed Removal of the HCP COVID–19 Vaccine Measure	−12.00	−$525.84	−178,416.00	−$7,818,189.12

b. ICRs for Proposed Removal of the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning With the FY 2028 SNF QRP

In section VI.D. of the proposed rule, we are proposing to remove the Patient/Resident COVID–19 Vaccine measure, and the MDS item that collects the measure data (O0350. Resident's COVID–19 vaccination is up to date) beginning with the FY 2028 SNF QRP. We identified the staff type based on past SNF burden calculations. We believe that the items would be completed equally by a registered nurse (RN) and a licensed practical and licensed vocational nurse (LPN/LVN). However, SNFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2024 National Occupational Employment and Wage Estimates.[38] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 18. We established a composite cost estimate using our adjusted wage estimates. The composite estimate of $78.16/hr was calculated by weighting each adjusted hourly wage equally (that is, 50 percent) [($61.68/hr × 0.5) plus ($94.64/hr × 0.5) = $78.16].

The net result of removing the related Patient/Resident COVID–19 Vaccine Status measure and the MDS item used to collect the measure data (O0350. Resident's COVID–19 vaccination is up to date) is a decrease of 0.3 minutes or 0.005 hour of clinical staff time. We estimate that the burden and cost for SNFs for complying with requirements of the FY 2028 SNF QRP would decrease under this proposal.

Using FY 2025 data, we estimate an annual total of 1,485,115 Discharge PPS assessments from 14,868 SNFs for an annual decrease of 7,425.58 hours (1,485,115 × 0.005 hour) for all SNFs. Given 0.005 hours at $78.16 per hour, we estimate the total cost to complete PPS Discharge assessments will decrease annually by $580,383.33 for all SNFs (7,425.58 hours × $78.16). For each SNF, we estimate an annual decrease in burden of 0.50 hours (7,425.58 hours/14,868 SNFs) and an annual decrease in cost of $39.04 ($580,383.33/14,868 SNFs).

The total estimated annual decrease in cost associated with the removal of the Patient/Resident COVID–19 Vaccine Status Measure beginning with the FY 2028 SNF QRP is summarized in Table 20.

TABLE 20—ESTIMATED BURDEN ASSOCIATED WITH OMB CONTROL NUMBER (CMS–10387) RELATED TO THE SNF QRP BEGINNING WITH THE FY 2028 SNF QRP

Requirement	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Proposed Removal of the Patient/Resident COVID–19 Vaccine Status Measure (O0350)	−0.50	−$39.04	−7,425.58	−$580,383.33

c. Summary of Proposed ICRs Beginning With the FY 2028 SNF QRP

In summary, as a result of the policies in this proposed rule that would begin with the FY 2028 SNF QRP, we estimate an annual decrease in burden of 185,841.58 hours for all SNFs or 12.50 hours per SNF. The total annual cost decrease is estimated at approximately $8,398,572.45 for all SNFs and $564.88 per SNF and is summarized in Table 21.

[37] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. May 2024. *https://www.bls.gov/oes/current/oes_stru.htm.*

[38] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. May 2024. *https://www.bls.gov/oes/current/oes_stru.htm.*

TABLE 21—ESTIMATED BURDEN ASSOCIATED WITH SNF QRP PROPOSALS BEGINNING WITH THE FY 2028 SNF QRP

Requirement	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Proposed Removal of the HCP COVID–19 Vaccine Measure	−12.00	−$525.84	−178,416.00	−$7,818,189.12
Proposed Removal of the Patient/Resident COVID–19 Vaccine Status Measure (O0350)	−0.50	−39.04	−7,425.58	−580,383.33
Total Estimated Change in Burden Beginning with the FY 2028 SNF QRP	−12.50	−564.88	−185,841.58	−8,398,572.45

We invite public comments on the proposed information collection requirements associated with the FY 2028 SNF QRP.

3. ICRs Regarding the Submission of MDS Data on All SNF Residents Beginning With the FY 2031 SNF QRP

As discussed in section VI.F.3. of this proposed rule, we are proposing that SNFs participating in the SNF QRP be required to submit MDS data on all residents regardless of payer when the resident is admitted to the SNF for covered skilled care. If this proposal is finalized, three items would be added to the MDS and one item on the MDS would be modified beginning with the FY 2031 SNF QRP to facilitate the submission of these data. To quantify the total estimated burden beginning with the FY 2031 SNF QRP, we first calculate the costs associated with the collection of information requirements for the three new items under the current SNF QRP data collection and submission requirements (that is, for Medicare fee-for-service (FFS) residents).[39] Second, we calculate the estimated costs associated with the collection of information requirements under the proposed SNF QRP data submission on all residents admitted for covered skilled care regardless of payer. For the costs related to new required assessments, we assume SNFs are already submitting MDS data on many non-Medicare FFS residents due to OBRA requirements and therefore new burden would only be attributed to non-Medicare FFS residents with a LOS <14 days and those non-Medicare FFS residents who are discharged to a non-skilled bed in the NF.

a. ICRs Regarding the Submission of Three New MDS Items Beginning With the FY 2031 SNF QRP

As discussed in section VI.F.3. of this proposed rule, if the proposal to submit MDS quality data on all residents admitted for covered skilled care regardless of payer is finalized, three new items would be added to the MDS beginning with the FY 2031 SNF QRP to facilitate the submission of these data. One new item would collect information on the resident's primary payer for a skilled stay at admission and discharge. A second item would capture the start and end dates of a covered skilled stay for a non-Medicare-FFS resident. A third item would be added to A0310. Type of Assessment to indicate whether an assessment is being completed for a non-Medicare-FFS resident at the time of discharge from skilled services. We believe the new items will be completed equally by a registered nurse (RN) or licensed practical and licensed vocational nurse (LPN/LVN). We identified the staff type based on past SNF burden calculations, and our assumptions are based on the categories generally necessary to collect this information. However, individual SNFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wage estimates for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2024 National Occupational Employment and Wage Estimates.[40] To account for other indirect costs and fringe benefits, we doubled the median hourly wage. These amounts are detailed in Table 18. We established a composite cost estimate using our adjusted hourly wage estimates. The composite estimate of $78.16/hr was calculated by weighting the adjusted hourly wage of the Registered Nurse (RN) and Licensed Practical and Licensed Vocational Nurse (LPN/LVN) equally [($61.68/hr × 0.5) plus ($94.64/hr × 0.5) = $78.16].

We estimate that the burden and cost for SNFs for complying with the requirements of the FY 2031 SNF QRP would increase under this proposal.

The result of collecting two new MDS items at admission is an increase of 0.6 minutes or 0.01 hour of clinical staff time [(2 items × 0.005 hour) = 0.01 hour]. Using FY 2025 data, we estimate a total of 1,584,102 5-day PPS assessments by 14,868 SNFs for an annual increase in burden of 15,841.02 hours for all SNFs at admission (1,584,102 5-day PPS assessments × 0.01 hour) or 1.07 hours per SNF at admission (15,841.02 hours/14,868 SNFs). We estimate the total annual increase in cost at admission would be $1,238,134.12 for all SNFs (15,841.02 hours × $78.16/hr) or $83.28 per SNF ($1,238,134.12/14,868 SNFs).

The result of collecting three new MDS items at discharge is an increase of 0.9 minutes or 0.015 hours of clinical staff time [(3 items × 0.005 hour) = 0.015 hours]. Using FY 2025 data, we also estimate a total of 1,485,115 Discharge PPS assessments by 14,868 SNFs for an annual increase in burden of 22,276.73 hours for all SNFs at discharge (1,485,115 Discharge PPS assessments × 0.015 hour) or 1.50 hours per SNF at discharge (22,276.73 hours/14,868 SNFs). We estimate the total annual increase in cost at discharge would be $1,741,149.22 for all SNFs (22,276.73 hours × $78.16/hr) or $117.11 per SNF ($1,741,149.22/14,868 SNFs).

The total estimated burden associated with the proposed collection of two new MDS items at admission and three new MDS items at discharge (as described in this section) is summarized in Table 22. The result of collecting new MDS items is an annual increase in burden of 38,117.75 hours for all SNFs (15,841.02 hours at admission + 22,276.73 hours at discharge), or 2.57 hours per SNF (1.07 hours at admission + 1.50 hours at

[39] Note that we are proposing a modification to one admission item that has no impact on burden, so is not included in the following calculations. The modification we are proposing is to add the response option '91. Other Skilled Care Admission Assessment' to MDS Item A0310B.

[40] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. May 2024. *https://www.bls.gov/oes/current/oes_stru.htm.*

discharge). We estimate the total annual increase in cost would be $2,979,283.34 ($1,238,134.12 at admission + $1,741,149.22 at discharge), or $200.39 for per SNF ($83.28 at admission + $117.11 at discharge).

The proposed increase in burden would be accounted for in a revised information collection request under OMB control number 0938–1140/CMS–10387 (Expiration Date: 11/30/2028).

TABLE 22—ESTIMATED BURDEN ASSOCIATED WITH OMB CONTROL NUMBER 0938–1140 (CMS–10387) RELATED TO THE SNF QRP BEGINNING WITH THE FY 2031 SNF QRP

Requirement	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Proposed submission of two new MDS items at admission and three New MDS Items at discharge	+2.57	+$200.39	+38,117.75	+$2,979,283.34

b. ICRs Regarding the Submission of MDS Data on All Residents Admitted for Covered Skilled Care Beginning With the FY 2031 SNF QRP

In section VI.F.3. of this proposed rule, we are proposing to update the data submission requirements for the SNF QRP beginning with the FY 2031 SNF QRP. We are proposing to require SNFs to submit MDS data on all residents regardless of payer when the resident is admitted for covered skilled care. Submitting MDS data on all residents regardless of payer would increase the burden on SNFs. However, as noted in section VI.F.3.(a), during two national SNF Listening Sessions hosted by our contractor in 2023 [41] and 2024,[42] we heard from SNFs that submitting data on all SNF residents is feasible. We also heard that some SNFs currently collect MDS data on all residents, regardless of payer, even though they do not submit them to CMS because they want to have the information in the event they retroactively find out the resident disenrolled from their non-FFS benefit prior to their SNF admission.

Most of this new burden would occur when a non-Medicare FFS resident's length of stay (LOS) is <14 days and/or they are discharged to a non-certified bed in the nursing facility (NF). Specifically, OBRA requirements already require SNFs to complete a comprehensive Admission assessment on all residents regardless of payer when a resident's LOS is equal to or greater than 14 days. Additionally, SNFs are required to complete a Discharge assessment on all residents regardless of payer when a resident is physically discharged from the SNF. Therefore, SNFs are already submitting MDS data on many of these non-Medicare FFS residents, and the new burden would only be attributed to non-Medicare FFS residents with a LOS <14 days and those non-Medicare FFS residents who are discharged to a non-skilled bed in the NF.

To estimate the number of new MDS assessments SNFs would submit under this proposed policy, CMS examined two characteristics of current Medicare FFS resident stays: (i) SNF practices for combining comprehensive (OBRA) and PPS item sets; and (ii) estimated LOS. First, regarding SNF practices for combining assessments, our finding was that in practice, SNFs already combine PPS and OBRA assessments a high percentage of the time. Specifically, SNFs combine 5-day PPS and OBRA Admission assessments 77.1 percent of the time, and Part A PPS Discharge assessments and OBRA Discharge assessments 70 percent of the time. For purposes of our estimate, we assume provider behavior will not change under a MDS submission policy for all residents regardless of payer. Specifically, we believe SNFs will combine assessments for non-Medicare FFS residents at admission and discharge at a similar rate to their Medicare FFS resident assessments. The second finding was that the average LOS for Medicare FFS beneficiaries was 27 days. However, public information suggests that nationally, resident stays covered by MA plans, Medicaid, and other payers are shorter, but still remain above the 14-day threshold and would already be required to submit an MDS assessment due to OBRA.[43]

We believe the MDS items collected on the PPS Item Set at admission and the Part A PPS Discharge Item Set are completed by RNs, LVNs, Speech-Language Pathologists (SLP), Occupational Therapists (OT), and/or Physical Therapists (PT), depending on the item. We identified the staff type based on past SNF burden calculations in conjunction with expert opinion who have informed us that interdisciplinary participation in MDS data collection has increased since the implementation of the PDPM. Individual providers determine the staffing resources necessary. To account for overhead and fringe benefits, we have doubled the (BLS) May 2024 National Occupational Employment and Wage Estimates median hourly wage found in Table 18. We established a composite cost estimate using our adjusted hourly wage estimates. The composite estimate of $88.28/hr was calculated by weighting each hourly wage equally [($61.68/hr × 0.2) plus ($94.46/hr × 0.2) plus ($98.46/hr × 0.2) plus ($94.64/hr × 0.2) plus ($92.16/hr × 0.2) = $88.28].

We estimate an additional 1,133,649 MDS assessments would be submitted from 14,868 SNFs annually. Given the expected time to complete an MDS, we estimate an annual increase of 963,601.65 hours for all SNFs and 64.81 hours per SNF (963,601.65 hours/14,868 SNFs).

We estimate the total annual cost related to the additional reporting requirements is $85,066,753.66 for all SNFs (963,601.65 × $88.28/hr). We estimate an annual increase in cost of $5,721.47 per SNF ($85,066,753.66/14,868 SNFs). The total annual burden and cost related to the additional reporting requirements is summarized in Table 23. The increase in burden will be accounted for in a revised

[41] Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Summary Report. August 29, 2023. Available at *https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf.*

[42] Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Summary Report. October 1, 2024. Available at *https://www.cms.gov/files/document/snfallpayerlisteningsession2024summaryreportv3508.pdf.*

[43] CMS' SNF MA public use file (PUF) reports LOS has declined from 23.19 days in 2016 to 19.44 days in 2021. (*https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-service-type-reports/cms-program-statistics-medicare-advantage-skilled-nursing-facility*).

information collection request under OMB control number 0938–1140. The required 60-day and 30-day notices would publish in the **Federal Register** and the comment periods will be separate from those associated with this rulemaking.

TABLE 23—ESTIMATED BURDEN ASSOCIATED WITH SUBMISSION OF MDS DATA ON ALL RESIDENTS ADMITTED FOR COVERED SKILLED CARE BEGINNING WITH THE FY 2031 SNF QRP

Requirement	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Proposed Submission of MDS Data on All Residents Admitted for Covered Skilled Care	+64.81	+$5,721.47	+963,601.65	+$85,066,753.66

c. Summary of ICRs Beginning With the FY 2031 SNF QRP

In summary, as a result of the policies in this proposed rule that would begin with the FY 2031 SNF QRP, we estimate an annual increase in burden of 1,001,719.40 hours for 14,868 SNFs or 67.38 hours per SNF. The total annual cost increase is estimated at approximately $88,046,037.00 for all SNFs and $5,921.86 per SNF and is summarized in Table 24. We invite public comments on the proposed information collection requirements and also on our assumptions and estimations of this burden.

TABLE 24—ESTIMATED BURDEN ASSOCIATED WITH SNF QRP PROPOSALS BEGINNING WITH THE FY 2031 SNF QRP

Requirement	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Proposed Collection of two new MDS items at Admission and three new MDS Items at Discharge	+2.57	+$200.39	+38,117.75	+$2,979,283.34
Proposed Submission of MDS Data on All Residents Admitted for Covered Skilled Care	+64.81	+5,721.47	+963,601.65	+85,066,753.66
Total Estimated Change in Burden Beginning with the FY 2031 SNF QRP	+67.38	+5,921.86	+1,001,719.40	+88,046,037.00

C. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed previously, please visit CMS' website at *https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule and identify the rule [CMS–1843–P], the ICR's CFR citation, CMS ID number, and OMB control number.

IX. Regulatory Impact Analysis

A. Statement of Need

1. Statutory Provisions

This proposed rule updates the FY 2026 SNF prospective payment rates as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register** before the August 1 that precedes the start of each FY, the unadjusted Federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. These are statutory provisions that prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, and we do not have the discretion to adopt an alternative approach on these issues.

With respect to the SNF QRP, we are proposing several updates as described in section VI. of this proposed rule. Specifically, we are proposing to remove the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) (HCP COVID–19 Vaccine) measure and the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure, beginning with the FY 2028 SNF QRP. We are also proposing to revise the SNF QRP Data Submission Deadlines beginning with the FY 2029 SNF QRP. Finally, we are proposing to require the submission of MDS data on all SNF residents regardless of payer, beginning with the FY 2031 SNF QRP.

With respect to the SNF VBP Program, this rule proposes updates to the SNF VBP Program requirements for FY 2027 and subsequent years as described in section VII. of this proposed rule. Specifically, section 1888(h)(3) of the Act requires the Secretary to establish and announce performance standards for SNF VBP Program measures no later than 60 days before the beginning of the performance period, and this proposed rule estimates numerical performance standards for the FY 2029 program year for the SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, Falls with

Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization measures; and numerical performance standards for the FY 2030 program year for the DTC PAC SNF and SNF WS PPR measures. We are also proposing to update the ''snapshot date'' codified at 42 CFR 413.338(f)(1)(v) for two measures that are calculated using MDS assessment data to maintain alignment with proposed SNF QRP submission deadlines for MDS assessment data, beginning with FY 2027 data, and proposing technical updates to our regulatory text.

2. Discretionary Provisions

This proposed rule does not include any discretionary provisions.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. Based on our estimates, the Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs (OIRA) has determined this rulemaking is significant per section 3(f)(1). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of the proposed rule.

C. Detailed Economic Analysis

1. Impacts for the FY 2027 SNF PPS

This rule updates the SNF PPS rates contained in the FY 2026 SNF PPS final rule (90 FR 37310). We estimate that the aggregate impact will be an increase of approximately $888 million (2.4 percent) in Part A payments to SNFs in FY 2027. These impact numbers do not incorporate the SNF VBP Program reductions that we estimate will total $208.36 million in FY 2027. We note that events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented, and thus, susceptible to forecasting errors due to events that may occur within the assessed impact time period.

In accordance with sections 1888(e)(4)(E) and (e)(5) of the Act and implementing regulations at 42 CFR 413.337(d), we are updating the FY 2026 payment rates by a factor equal to the market basket percentage increase reduced by the productivity adjustment to determine the payment rates for FY 2027. The impact to Medicare is included in the total column of Table 25. The annual payment rate update in this rule applies to SNF PPS payments in FY 2027. Accordingly, the analysis of the impact of the annual update that follows only describes the impact of this single year. Furthermore, in accordance with the requirements of the Act, we will publish a rule or notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

The FY 2027 SNF PPS payment impacts appear in Table 25. Using the most recently available claims data, in this case FY 2025, we apply the current FY 2026 case-mix indices (CMIs), wage index and labor-related share value to the number of payment days to simulate FY 2026 payments. Then, using the same FY 2025 claims data, we apply the proposed FY 2027 case-mix indices, wage index and labor-related share value to simulate FY 2027 payments. We tabulate the resulting payments according to the classifications in Table 25 (for example, facility type, geographic region, facility ownership) and compare the simulated FY 2026 payments to the simulated FY 2027 payments to determine the overall impact. The breakdown of the various categories of data in Table 25 is as follows:

- The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, census region, and ownership.
- The first row of figures describes the estimated effects of the various changes contained in this proposed rule on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The next nineteen rows show the effects on facilities by urban versus rural status by census region. The last three rows show the effects on facilities by ownership (that is, government, for-profit, and non-profit status).
- The second column shows the number of facilities in the impact database.
- The third column shows the effect of the annual update to the wage index, including the updates to the labor related-share discussed in section III.D. of this rule. This represents the effect of using the most recent wage data available as well as accounts for the 5 percent cap on wage index decreases. The total impact of this change is 0.0 percent. However, there are distributional effects of the change.
- The fourth column shows the net (total) effect of all of the changes on the FY 2027 SNF PPS payments. This column reflects the overall 2.4 percent update applicable to all providers plus or minus the wage index adjustment in column 3. It is projected that aggregate payments will increase by 2.4 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 25, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes in this rule, rural providers will experience a 2.7 percent increase in FY 2027 total payments.

TABLE 25—IMPACT TO THE SNF PPS FOR FY 2027

Impact categories	Number of facilities	Update wage data	Total change (%)
Group			
Total	14,868	0.0	2.4
Urban	10,803	0.0	2.4
Rural	4,065	0.3	2.7
Hospital-based urban	301	0.5	2.9
Freestanding urban	10,502	−0.1	2.3
Hospital-based rural	339	0.4	2.8
Freestanding rural	3,726	0.3	2.7
Urban by region			
New England	678	0.1	2.5
Middle Atlantic	1,426	1.4	3.8
South Atlantic	1,863	−0.9	1.5
East North Central	2,085	−0.8	1.6
East South Central	548	−0.8	1.5
West North Central	905	−0.1	2.3
West South Central	1,378	−0.8	1.6
Mountain	526	−0.4	1.9
Pacific	1,388	0.1	2.5
Outlying	6	1.9	4.4
Rural by region			
New England	112	2.1	4.6
Middle Atlantic	214	0.7	3.1
South Atlantic	524	1.7	4.1
East North Central	848	0.2	2.6
East South Central	482	−0.2	2.2
West North Central	934	0.7	3.1
West South Central	685	−1.4	1.0
Mountain	182	−1.8	0.5
Pacific	83	1.7	4.2
Outlying	1	−0.1	2.3
Ownership			
For-profit	10,819	0.0	2.4
Non-profit	3,090	−0.1	2.3
Government	959	−0.5	1.9

Note: The Total column includes the proposed FY 2027 SNF market basket update of 2.4 percent. The values presented in Table 25 may not sum due to rounding.

2. Impacts for the SNF QRP Beginning FY 2028 and Beginning FY 2031

Estimated impacts for the SNF QRP are based on analysis discussed in section VI. of the proposed rule. In accordance with section 1888(e)(6)(A)(i) of the Act, the Secretary must reduce by 2 percentage points the annual payment update applicable to a SNF for a fiscal year if the SNF does not comply with the requirements of the SNF QRP for that fiscal year.

a. Impacts for Proposed Updates Related to the SNF QRP Beginning With the FY 2028 SNF QRP

As discussed in section VI.C. of this proposed rule, we are proposing to remove the HCP COVID–19 Vaccine measure beginning with the FY 2028 SNF QRP. If the proposal is finalized, we estimate a decrease in burden of 12 hours and $525.84 per SNF per year. We estimate this equates to a decrease in burden of 178,416 hours and $7,818,189.12 for all SNFs annually ($525.84 × 14,868 SNFs).

As discussed in section VI.D. of this proposed rule, we are proposing to remove the Patient/Resident COVID–19 Vaccine measure beginning with the FY 2028 SNF QRP. If the proposal is finalized, we estimate a decrease in burden of 0.50 hours and $39.04 per SNF per year. We estimate this equates to a decrease in burden of 7,425.58 hours and $580,383.33 for all SNFs annually (7,425.58 hours × $78.16).

b. Impacts for Submission of Data on All SNF Residents Beginning With the FY 2031 SNF QRP

As discussed in section VI.F.3. of this proposed rule, we are proposing that SNFs participating in the SNF QRP be required to submit MDS data on all residents admitted for covered skilled care regardless of payer beginning with residents admitted on October 1, 2029 for the FY 2031 SNF QRP. Although the increase in burden for submitting MDS data on all residents admitted for covered skilled care regardless of payer will be accounted for in a revised information collection request under OMB control number (0938–1140), we are providing estimated impact information as reflected in Table 26.

(1) Impacts for Submission of Three New MDS Items Beginning With the FY 2031 SNF QRP

As discussed in section VIII.B.2.a. of this proposed rule, we estimate the net result of this proposal will increase burden. If the proposal is finalized, three items would be added to the MDS. One new item would collect information on the resident's primary

payer for a skilled stay at admission and discharge. A second item would capture the start and ends dates of a covered skilled stay for a non-Medicare-FFS resident. A third item would be added to the Type of Assessment section of the MDS to indicate whether an assessment is being completed for a non-Medicare-FFS resident at the time of discharge from skilled services.

Using FY 2025 data, we estimate a total of 1,584,102 5-day PPS assessments for an annual increase in burden of 15,841.02 hours and an increased cost of $1,238,134.12 (15,841.02 hours × $78.16/hr) for all SNFs at admission. For each SNF, we estimate an annual burden increase of 1.07 hours at an additional cost of $83.28 at admission. Using FY 2025 data, we also estimate a total of 1,485,115 Discharge PPS assessments for an annual increase in burden of 22,276.73 hours and an increase cost of $1,741,149.22 (22,276.73 hours × $78.16/hr) for all SNFs at discharge. For each SNF, we estimate an annual burden increase of 1.50 hours at an additional cost of $117.11 at discharge.

The result of collecting new MDS items is an annual burden increase of 38,117.75 hours for all SNFs or 2.57 hours per SNF. We estimate the total annual cost would increase by $2,979,283.34 or $200.39 per SNF.

(2) Impacts for the Submission of MDS Quality Data on All Residents Admitted for Covered Skilled Care Beginning With the FY 2031 SNF QRP

As discussed in section VIII.B.2.b. of this proposed rule, we estimate the net result of this proposal will increase burden. If the proposal to collect and submit MDS quality data on all residents admitted for covered skilled care regardless of payer is finalized, we estimate an additional 1,133,649 MDS assessments would be collected from 14,868 SNFs annually. This equates to an increase of 963,601.65 hours in burden for all SNFs and an increase of $85,066,753.66 (963,601.65 hours × $88.28/hr). For each SNF, we estimate an annual burden increase of 64.81 hours at an additional cost of $5,721.47.

We invite public comments on the overall impact of the SNF QRP proposals for FY 2028 and FY 2031 displayed in Tables 26 and 27 respectively.

TABLE 26—ESTIMATED IMPACTS FOR THE FY 2028 SNF QRP

Estimated impacts for the FY2028 SNF QRP	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden Associated with Removal of the HCP COVID–19 Vaccine Measure Beginning with the FY 2028 SNF QRP	−12.00	−$525.84	−178,416	−$7,818,189.12
Estimated Change in Burden Associated with Removal of the Patient/Resident COVID–19 Vaccine Measure Beginning with the FY 2028 SNF QRP	−0.50	−39.04	−7,425.58	−580,383.33
Total Estimated Change in Burden Beginning with the FY 2028 SNF QRP	−12.50	−564.88	−185,841.58	−8,398,572.45

TABLE 27—ESTIMATED IMPACTS FOR THE FY 2031 SNF QRP

Estimated impacts for the FY2031 SNF QRP	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden Associated with Collection and Submission of Two MDS Items at Admission and Discharge and One MDS Item at Discharge Beginning with the FY 2031 SNF QRP	+2.57	+$200.39	+38,117.75	+$2,979,283.34
Estimated Change in Burden Associated with Proposed Collection and Submission of MDS Data on All Residents Admitted for Covered Skilled Care Beginning with the FY 2031 SNF QRP	+64.81	+5,721.47	+963,601.65	+85,066,753.66
Total Estimated Change in Burden Beginning with the FY 2031 SNF QRP	+67.38	+5,921.86	+1,001,719.40	+88,046,037.00

3. Impacts for the SNF VBP Program

The estimated impacts of the FY 2027 SNF VBP Program are based on historical data and appear in Tables 28 through 30. We modeled SNF performance in the Program using SNFRM, SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization measure results from FY 2022 as the baseline period and FY 2024 as the performance period, and using DTC PAC SNF measure results from FY 2020–FY 2021 as the baseline period and FY 2023–FY 2024 as the performance period. Additionally, we modeled a logistic exchange function with a payback percentage of 60 percent, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36619 through 36621).

For the FY 2027 program year, we will reduce each SNF's adjusted Federal per diem rate by 2 percent, as required by section 1888(h)(6)(B) of the Act. This 2 percent is referred to as the ''withhold.'' We will then redistribute 60 percent of that 2 percent withhold to SNFs based on their measure performance. Additionally, in the FY 2023 SNF PPS final rule (87 FR 47585 through 47587), we finalized a case

minimum requirement for the SNFRM, Total Nurse Staffing, SNF HAI, and DTC PAC SNF measures, and in the FY 2024 SNF PPS final rule (88 FR 53301 through 53302) we finalized a case minimum requirement for the Nursing Staff Turnover, Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization measures, as required by section 1888(h)(1)(C)(i) of the Act. Furthermore, in the FY 2024 SNF PPS final rule (88 FR 53302 through 53303), we finalized the measure minimum requirement for the FY 2027 SNF VBP program year, as required by section 1888(h)(1)(C)(ii) of the Act. As a result of these provisions, SNFs must meet the case minimum requirement for at least four of the eight measures during the applicable performance period to receive a SNF performance score and to receive a value-based incentive payment for FY 2027; SNFs that do not meet this measure minimum requirement finalized for the FY 2027 program year will be excluded from the Program and will receive their adjusted Federal per diem rate for that fiscal year. As previously finalized, this policy will maintain the overall payback percentage at 60 percent for the FY 2027 program year. Based on the 60 percent payback percentage, we estimated that we will redistribute approximately $305.11 million (of the estimated $508.52 million in withheld funds) in value-based incentive payments to SNFs in FY 2027, which means that the SNF VBP Program is estimated to result in approximately $203.41 million in savings to the Medicare Program in FY 2027.

Our detailed analysis of the impacts of the FY 2027 SNF VBP Program is shown in Tables 28 through 30.

TABLE 28—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2027

Characteristic	Number of facilities	Mean risk-standardized readmission rate (SNFRM) (%)	Mean total nursing hours per resident day (total nurse staffing)	Mean risk-standardized rate of healthcare-associated infections (SNF HAI) (%)	Mean total nursing staff turnover rate (nursing staff turnover) (%)
Group					
Total *	13,257	20.48	3.84	7.26	47.49
Urban	9,790	20.56	3.83	7.26	47.50
Rural	3,467	20.28	3.89	7.24	47.46
Hospital-based urban	227	20.29	4.81	6.55	40.46
Freestanding urban	9,563	20.56	3.80	7.28	47.66
Hospital-based rural	126	19.97	4.95	6.54	38.81
Freestanding rural	3,341	20.29	3.85	7.26	47.77
Urban by region					
New England	655	20.77	3.91	6.98	43.47
Middle Atlantic	1,348	20.22	3.75	7.22	43.00
South Atlantic	1,768	20.71	3.83	7.38	46.85
East North Central	1,788	20.77	3.53	7.18	49.51
East South Central	511	20.78	3.90	7.30	51.35
West North Central	781	20.43	4.20	7.04	51.86
West South Central	1,166	20.95	3.74	7.49	53.38
Mountain	473	19.87	3.80	6.83	50.35
Pacific	1,298	20.17	4.11	7.46	41.94
Outlying	2	21.74	4.18	6.77	14.84
Rural by region					
New England	101	19.99	4.19	6.90	50.43
Middle Atlantic	198	19.96	3.78	7.03	48.10
South Atlantic	459	20.34	3.68	7.32	46.36
East North Central	738	20.23	3.58	7.12	46.22
East South Central	421	20.59	4.00	7.49	44.42
West North Central	742	20.11	4.18	7.17	48.95
West South Central	549	20.80	3.88	7.59	48.49
Mountain	175	19.67	3.96	6.74	51.57
Pacific	84	19.02	4.31	6.74	46.71
Outlying	N/A	N/A	N/A	N/A	N/A
Ownership					
Government	733	20.33	4.29	7.11	44.44
Profit	9,948	20.56	3.64	7.38	48.73
Non-Profit	2,576	20.22	4.51	6.80	43.46

* The total group category excludes 1,552 SNFs that failed to meet the finalized measure minimum requirement.
N/A = Not available because no facilities in this group received a measure result.

TABLE 29—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2027

Characteristic	Number of facilities	Mean risk-standardized discharge to community rate (DTC PAC SNF) (%)	Mean number of risk-adjusted hospitalizations per 1,000 long-stay resident days (long stay hospitalization)	Mean percentage of stays meeting or exceeding expected discharge function score (DC function) (%)	Mean percentage of stays with a fall with major injury (falls with major injury (long-stay)) (%)
Group					
Total *	13,257	50.54	1.81	52.87	3.31
Urban	9,790	51.29	1.84	52.85	3.05
Rural	3,467	48.39	1.70	52.93	4.04
Hospital-based urban	227	58.58	1.64	51.45	2.51
Freestanding urban	9,563	51.12	1.85	52.89	3.06
Hospital-based rural	126	53.63	1.38	51.96	4.05
Freestanding rural	3,341	48.21	1.71	52.96	4.04
Urban by region					
New England	655	54.70	1.78	54.27	3.73
Middle Atlantic	1,348	49.67	1.73	55.76	2.90
South Atlantic	1,768	51.10	1.85	51.88	3.08
East North Central	1,788	51.69	1.71	50.75	3.32
East South Central	511	51.17	1.86	50.61	3.31
West North Central	781	50.52	1.76	54.72	3.70
West South Central	1,166	49.04	2.15	51.78	3.34
Mountain	473	56.00	1.45	57.90	2.60
Pacific	1,298	51.78	2.07	52.23	1.88
Outlying	2	60.48	0.00	43.21	0.00
Rural by region					
New England	101	51.69	1.45	53.46	4.71
Middle Atlantic	198	45.52	1.39	51.58	3.68
South Atlantic	459	48.26	1.74	50.75	3.52
East North Central	738	50.98	1.61	50.30	4.04
East South Central	421	47.96	1.95	48.58	3.79
West North Central	742	46.21	1.55	55.59	4.42
West South Central	549	47.24	2.19	55.89	4.13
Mountain	175	50.83	1.17	59.75	4.41
Pacific	84	53.76	1.17	56.57	3.32
Outlying	N/A	N/A	N/A	N/A	N/A
Ownership					
Government	733	49.13	1.74	52.78	3.85
Profit	9,948	49.87	1.87	52.33	3.11
Non-Profit	2,576	53.52	1.57	55.02	3.95

* The total group category excludes 1,552 SNFs that failed to meet the finalized measure minimum requirement.
N/A = Not available because no facilities in this group received a measure result.

TABLE 30—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2027

Characteristic	Number of facilities	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Group				
Total *	13,257	35.6850	0.99067	100.00
Urban	9,790	36.0063	0.99088	86.60
Rural	3,467	34.7778	0.99009	13.40
Hospital-based urban	227	48.3943	1.00011	1.65
Freestanding urban	9,563	35.7123	0.99066	84.95
Hospital-based rural	126	47.8633	0.99954	0.31
Freestanding rural	3,341	34.2843	0.98973	13.09
Urban by region				
New England	655	37.8333	0.99175	5.38

TABLE 30—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2027—Continued

Characteristic	Number of facilities	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Middle Atlantic	1,348	37.7825	0.99177	19.84
South Atlantic	1,768	35.0550	0.99024	16.25
East North Central	1,788	33.6982	0.98933	10.41
East South Central	511	33.1952	0.98907	2.85
West North Central	781	36.6894	0.99168	3.60
West South Central	1,166	29.8160	0.98720	6.47
Mountain	473	42.7563	0.99550	3.75
Pacific	1,298	41.4817	0.99437	18.04
Outlying	2	55.5748	1.00503	0.00
Rural by region				
New England	101	38.6689	0.99234	0.56
Middle Atlantic	198	34.4592	0.98943	0.97
South Atlantic	459	32.9504	0.98893	2.18
East North Central	738	35.0783	0.99035	2.83
East South Central	421	33.3598	0.98907	1.68
West North Central	742	36.4913	0.99126	1.80
West South Central	549	30.4066	0.98725	2.09
Mountain	175	40.7058	0.99401	0.60
Pacific	84	46.3840	0.99817	0.70
Outlying	N/A	N/A	N/A	N/A
Ownership				
Government	733	39.1976	0.99313	3.01
Profit	9,948	33.5631	0.98919	81.32
Non-Profit	2,576	42.8799	0.99571	15.67

* The total group category excludes 1,552 SNFs that failed to meet the finalized measure minimum requirement. The total group category includes 55 SNFs that did not have historical payment data used for this analysis.
N/A = Not available because no facilities in this group met the finalized measure minimum requirement.

D. Alternatives Considered

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating base payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the SNF PPS payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995). In accordance with the statute, we also incorporated a number of elements into the SNF PPS (for example, case-mix classification methodology, a market basket update, a wage index, and the urban and rural distinction used in the development or adjustment of the Federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY. Accordingly, we are not pursuing alternatives for this process.

With regard to the proposals to remove both the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) and COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, we considered keeping both measures. However, when these measures were adopted, there were well-defined parameters for receiving the COVID–19 vaccination. We determined that these measures no longer align with current clinical guidelines, and therefore the publicly reported measures may not be reliably give consumers information on the percent of HCP or residents that are vaccinated in a SNF.

With regard to the proposal to revise the SNF QRP assessment data submission deadline from 4.5 months to no later than the 15th day of the second month after the end of each quarter, we considered keeping the deadline unchanged. We determined that the revised timeframe is a reasonable amount of time for SNFs to submit data and make any necessary corrections, and that the benefits of this shortened timeframe include making the data timelier and more actionable which increases the value of publicly reported data both for consumers and their families and for SNFs to use in their quality improvement activities.

With regard to the proposal to collect and submit MDS data on all SNF residents regardless of payer, we believe the data could support SNFs in their quality improvement activities and contribute to better healthcare outcomes for our beneficiaries by enabling them to make more informed decisions. Furthermore, we believe that proposing this policy aligns with CMS' aims to pursue greater program alignment through standardization of data collection and submission on a consistent patient/resident population across provider settings.

With regard to the proposals for the SNF VBP Program, we discussed alternatives considered within those sections.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this

year's proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's proposed rule in detail, and it is also possible that some reviewers chose not to comment on last year's proposed rule. For these reasons, we believe that the number of commenters on last year's proposed rule is a fair estimate of the number of reviewers of this year's proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

The median wage rate for medical and health service managers (SOC 11–9111) in the May 2024 BLS Occupational Employment Wage Statistics is $56.71, assuming benefits plus other overhead costs equal 100 percent of wage rate, we estimate that the cost of reviewing this rule is $113.42 per hour, including overhead and fringe benefits. The median wage rate can be found at the following website: *https://www.bls.gov/oes/current/oes_nat.htm.* Assuming an average reading speed, we estimate that it will take approximately 4 hours for the staff to review half of this proposed rule. For each SNF that reviews the rule, the estimated cost is $453.68 (4 hours × $113.42). Therefore, we estimate that the total cost of reviewing this regulation is $33,572.32 ($453.68 × 74 reviewers).

F. Accounting Statements and Tables

Consistent with OMB Circular A–4 (available online at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*), in Tables 31 through 34, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule for FY 2027. Tables 25 and 31 provide our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies outlined in this rule, based on the data for 14,868 SNFs in our database. Tables 32 and 33 provide our best estimate of the additional cost to SNFs to submit the data for the SNF QRP as a result of the policies outlined in this final rule. Table 34 provides our best estimate of the possible changes in Medicare payments under the SNF VBP as a result of the policies for this program.

TABLE 31—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE FY 2026 SNF PPS TO THE FY 2027 SNF PPS

Category	Transfers
Annualized Monetized Transfers From Whom To Whom?	$888 million. Federal Government to SNF Medicare Providers.

TABLE 32—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED SAVINGS FOR THE CHANGES TO THE FY 2028 SNF QRP

Category	Costs
Estimated Savings to SNFs for Proposed Changes to the FY 2028 QRP.	−$8.4 million.

TABLE 33—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE CHANGES TO THE FY 2031 SNF QRP

Category	Costs
Estimated Costs to SNFs for Proposed Changes to the FY 2031 QRP	$88.0 million.

TABLE 34—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE FY 2027 SNF VBP PROGRAM

Category	Transfers
Annualized Monetized Transfers From Whom To Whom?	$305.11 million.* Federal Government to SNF Medicare Providers.

* This estimate does not include the 2 percent reduction to SNFs' Medicare payments (estimated to be $508.52 million) required by statute.

G. Conclusion

This rule updates the SNF PPS rates contained in the FY 2026 SNF PPS final rule (90 FR 37310). We estimate that the overall payments for SNFs under the SNF PPS in FY 2027 are projected to increase by approximately $888 million, or 2.4 percent, compared with those in FY 2026. We estimate that in FY 2027, SNFs in urban and rural areas will experience, on average, a 2.4 percent increase and 2.7 percent increase, respectively, in estimated payments compared with FY 2026. Providers in the rural New England region will experience the largest estimated increase in payments of approximately 4.6 percent. Providers in the rural Mountain region will experience the smallest estimated increase in payments of 0.5 percent.

H. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers

are small entities, either by reason of their non-profit status or by having revenues of $30 million or less in any 1 year. We utilized the revenues of individual SNF providers (from recent Medicare Cost Reports) to classify a small business, and not the revenue of a larger firm with which they may be affiliated. As a result, for the purposes of the RFA, we estimate that almost all SNFs are small entities as that term is used in the RFA, according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $34 million or less in any 1 year. (For *details, see the Small Business Administration's* website *at https://www.sba.gov/document/support-table-size-standards*). In addition, approximately 20 percent of SNFs classified as small entities are non-profit organizations. Finally, individuals and States are not included in the definition of a small entity.

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2026 (90 FR 37310). We estimate that the aggregate impact for FY 2027 will be an increase of $888 million in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 25 that all providers will experience a net increase in payments, we note that some individual providers within the same region or group may experience different impacts on payments than others due to the distributional impact of the FY 2027 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. In their March 2025 Report to Congress (available at *https://www.medpac.gov/wp-content/uploads/2025/03/Mar25*), MedPAC states that Fee-for-Service Medicare accounted for approximately 8 percent of total patient days in freestanding facilities and 14 percent of facility revenue in 2022. As indicated in Table 25, the effect on facilities is projected to be an aggregate positive impact of 2.4 percent for FY 2027. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent of the total revenue. Since Medicare accounts for only 14 percent of SNF total revenue, the resulting impact of this rule is 0.34 percent (14 percent of 2.4 percent). As the overall impact on small entities does not meet the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed rule will not have a significant impact on a substantial number of small entities for FY 2027. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. This proposed rule will affect small rural hospitals that: (1) furnish SNF services under a swing-bed agreement; or (2) have a hospital-based SNF. We anticipate that the impact on small rural hospitals will be similar to the impact on SNF providers overall. Moreover, as noted in previous SNF PPS final rules (most recently, the one for FY 2026 (90 FR 37310)), the category of small rural hospitals is included within the analysis of the impact of the rule on small entities in general. As the overall impact on the industry as a whole does not meet the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed rule will not have a significant impact on a substantial number of small rural hospitals for FY 2027.

I. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This proposed rule would not impose mandates on State, local, or Tribal governments or on the private sector.

J. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent proposed rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. This proposed rule will have no substantial direct effect on State and local governments, preempt State law, or otherwise have federalism implications.

K. E.O. 14192, ''Unleashing Prosperity Through Deregulation''

Executive Order 14192, entitled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' This rule is expected to be an E.O. 14192 regulatory action. We estimated that this rule will generate $47.09 million in annualized cost at a 7 percent discount rate, discounted relative to year 2024, over a perpetual time horizon.

X. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 31, 2026.

List of Subjects in 42 CFR Part 413

Diseases, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR part 413 as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

■ 1. The authority citation for part 413 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395m, 1395x(v), 1395x(kkk), 1395hh, 1395rr, 1395tt, and 1395ww.

■ 2. Section 413.338 is amended by revising paragraphs (f)(1)(v), (k)(3), and (l)(3) to read as follows:

§ 413.338 Skilled nursing facility value-based purchasing program.

* * * * *

(f) * * *

(1) * * *

(v) For the Discharge Function Score for SNFs (''DC Function measure'') and the Percent of Residents Experiencing One of More Falls with Major Injury

(Long Stay) (''Falls with Major Injury (Long Stay)'') measure, beginning with data collected in FY 2023, and ending with data collected in FY 2026, the specified date is the February 15th that is approximately 4.5 months after the last day of the applicable baseline period or performance period. Beginning with data collected in FY 2027, the specified date is the 15th day of the second month after the last day of the applicable baseline period or performance period. However, if the 15th day of the second month after the last day of the applicable baseline period or performance period falls on a Friday, weekend, or Federal holiday, the date is delayed until 11:59 p.m. EST on the next business day.

* * * * *

(k) * * *

(3) Upon a determination by CMS that the continued requirement for SNFs to submit data on a measure specified under paragraph (k)(2) of this section raises specific resident safety concerns, CMS may elect to immediately remove the measure from the SNF VBP Program. Upon removal of the measure, CMS will provide notice to SNFs and the public, along with a statement of the specific patient safety concern that would be raised if SNFs continued to submit data on the measure. CMS will also provide notice of the removal in the **Federal Register**.

* * * * *

(l) * * *

(3) Except as provided in paragraph (l)(4) of this section, CMS will not consider an exception request unless the SNF requesting such exception has complied fully with the requirements in paragraph (l)(2) of this section.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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