Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027 [CMS-1843-P]

Summary

On April 7, 2026, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (91 FR 17678) a proposed rule updating for fiscal year (FY) 2027 the Medicare skilled nursing facility (SNF) payment rates, SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing Program (VBP). The proposed rule also includes a request for information (RFI) on updating the Patient Driven Payment Model (PDPM) to address case-mix upcoding and improve payment accuracy. In addition, the CMS seeks comments on whether it should consider using alternative data sources to construct a SNF-specific wage index for potential use in future years.

For the SNF quality reporting program (QRP), CMS proposes to remove beginning with the FY 2028 SNF QRP the COVID-19 Vaccination Coverage Among Healthcare Personnel (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. In addition, beginning with the FY 2029 SNF QRP, CMS proposes changes to the SNF QRP data submission deadlines and, beginning with the FY 2031 QRP, to require the submission of Minimum Data Set (MDS) data on all residents receiving covered skilled care in a SNF. The agency also issues an REF regarding a future measure concept on advanced care planning. For the SNF Value-Based Purchasing Program (VBP), CMS provides estimated numerical performance standards for the FY 2029 and 2030 program years. The agency also proposes to modify the snapshot dates used for purposes of the SNF VBP review and corrections process to align with the agency's proposal to revise the SNF QRP's submission deadline for MDS assessment data.

CMS estimates that the overall impact of the proposed rule will be an increase of $888 million (+2.4 percent) in Medicare payments to SNFs during FY 2027. Wage index tables are no longer published in the Federal Register. Instead, these tables are available exclusively at: Wage Index | CMS.

Comments on the proposed rule are due by June 1, 2026.

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I. Background on SNF PPS

CMS reviews relevant statutory and regulatory history, including the Protecting Access to Medicare Act (PAMA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. PAMA required the Secretary to establish a Medicare SNF VBP Program. The IMPACT Act required the Secretary to implement a quality reporting program for SNFs and requires SNFs to report standardized data for specified quality and resource use domains. The Consolidated Appropriations Act, 2021 (CAA, 2021) authorized the Secretary to apply up to nine additional measures to the VBP program for SNFs. CMS also notes that section 1888(e)(4) of the Social Security Act (the Act) requires that the SNF Prospective Payment System (PPS) be updated annually and that certain elements be published in the Federal Register, including the unadjusted federal per diem rates for covered SNF services, the applicable case-mix classification system, and the factors to be applied in making the area wage adjustment for these ser7vices.

II. SNF PPS Rate Setting Methodology and FY 2027 Update

A summary of key data under the proposals for the SNF PPS for FY 2027 is presented below with additional details in the subsequent sections.

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Summary of Key Data under Proposed SNF PPS for FY 2027	
Market basket update factor	
Market basket increase	+3.2%
Forecast error adjustment for FY 2025*	+0.0%
Total Factor Productivity (TFP) adjustment	-0.8%
Net TFP-adjusted update	**+2.4%**
Wage index budget neutrality adjustment	0.9987
Labor-related share	72.0%

* The actual increase for FY 2025 was 0.2 percentage points lower than the estimated increase but did not exceed the 0.5 percentage point threshold for a forecast error adjustment.

A. Federal Base Rates

CMS reviews the history of the process for setting the federal base rates.

B. SNF Market Basket Update

CMS proposes a market basket increase for FY 2027 of 3.2 percent based on the fourth quarter 2025 forecast from IHS Global Insight, Inc. (IGI), with historical data through the third quarter of 2024. The forecast is based on the 2022-based SNF market basket before application of the forecast error adjustments and productivity adjustment.

For FY 2025, the most recent year for which actual data are available, CMS applied a market basket of 2.8 percent, but the actual increase was 3.0 percent. As the difference (0.2 percentage points) does not exceed the 0.5 percentage point threshold for making a forecast error correction, the FY 2027 market basket percentage increase of 3.2 percent is not adjusted.

The total factor productivity (TFP) adjustment required under the Affordable Care Act (ACA) is estimated to be 0.8 percentage points. CMS uses the TFP adjustment as calculated by the Bureau of Labor Statistics (BLS).[1] The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in MFP for the period ending September 30, 2027, based on IGI's fourth quarter 2025 forecast.

Thus, the resulting productivity-adjusted FY 2027 SNF market basket increase is equal to 2.4 percent (market basket increase of 3.2 percent less the 0.8 percentage point productivity adjustment).

CMS also proposes to apply a 2.0 percentage point reduction to the SNF market basket percentage changes for SNFs that do not satisfy the reporting requirements for the FY 2027 SNF QRP.

Based on the proposed productivity-adjusted update, CMS proposes FY 2027 unadjusted federal rates for each component of the payment for urban and rural areas that are shown in the tables

[1] Beginning with the November 18, 2021 release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP).

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below. Under the Patient Driven Payment Model (PDPM) case-mix classification system, the unadjusted federal per diem rates are divided into six components. Five of these are case-mix adjusted components: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA). The remaining component is a non-case-mix component, as existed under the previous RUG-IV classification system.

Final FY 2026 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$75.73	$86.33
Occupational Therapy	$70.49	$79.29
Speech-Language Pathology	$28.28	$35.63
Nursing	$132.00	$126.12
Non-Therapy Ancillaries	$99.59	$95.15
Non-case mix adjusted	$118.21	$120.40

Proposed FY 2027 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$77.45	$88.29
Occupational Therapy	$72.09	$81.09
Speech-Language Pathology	$28.92	$36.44
Nursing	$134.99	$128.98
Non-Therapy Ancillaries	$101.85	$97.31
Non-case mix adjusted	$120.89	$123.13

C. Case-Mix Adjustment

CMS replaced its previous case-mix classification methodology, the RUG-IV model, with the PDPM effective October 1, 2019. The PDPM model was designed to classify patients into payment groups based on patient characteristics, rather than the volume of therapy services provided to patients, as was done in the RUG-IV model. The proposed FY 2027 payment rates reflect the use of the PDPM classification system from October 1, 2026 through September 30, 2027. Tables 5 and 6 of the proposed rule (reproduced in the appendix to this summary) show the proposed PDPM case-mix adjusted federal rates and associated indexes listed separately for urban and rural SNFs. These rates do not reflect adjustments that may be made to the SNF PPS rates as a result of the SNF VBP Program.

D. Wage Index Adjustment

CMS proposes to continue to apply the wage index adjustment to the labor-related portion of the federal rate using the pre-reclassified inpatient prospective payment system (IPPS) hospital wage data, without applying the occupational mix, the rural floor, or outmigration adjustments, as the basis for the SNF PPS wage index. For FY 2027, CMS proposes to use updated wage data for hospital cost reporting periods in FY 2023. It notes that to use wage data from SNF cost reports would require audits that would burden SNFs and require a commitment of resources from CMS and the Medicare Administrative Contractors that is not feasible at this time.

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As CMS is using the IPPS wage index to adjust SNF payments for the area difference in the cost of labor, it must have a policy when there is a SNF in an urban or rural area that has no hospitals, and therefore, no applicable wage index. CMS proposes to use the same policy it has used in prior years. For rural areas without hospitals, CMS would use the average wage index from all contiguous urban areas as the SNF proxy wage index. For FY 2027, CMS has determined that the only rural area without wage index data available is North Dakota. For urban areas without hospitals, CMS would use the average wage index of all urban areas within the state as the SNF proxy wage index. These policies are only applicable in one urban area—CBSA 25980, Hinesville-Fort Stewart, Georgia.

In the FY 2023 SNF final rule (87 FR 47521-47525), CMS 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. CMS also finalized 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.

In FY 2025 CMS adopted the revised Office of Management and Budget (OMB) delineations identified in OMB Bulletin No. 23-01.[2] For 2027, CMS proposes to maintain the current CBSA delineations.

CMS applies the wage index adjustment to the labor-related portion of the federal rate. The labor-related share is the sum of the 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 based on the 2022-based SNF market basket is discussed in detail in the FY 2025 SNF PPS final rule (89 FR 64080 through 64081).

CMS uses a four-step process to trend forward the 2022 base year weights to FY 2027 price levels. This process includes computing the FY 2027 price index level for the total market basket and each cost category of the market basket. Based on this update, the proposed SNF labor-related share is 72.0 percent, compared to a FY 2026 final labor-related share of 71.0 percent. Table 7 in the proposed rule summarizes the proposed labor-related share for FY 2027 (based on the IGI fourth quarter 2025 forecast) compared with FY 2026 for each of the cost categories.

To calculate the labor portion of the case-mix adjusted per diem rate, CMS multiplies 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 would be the non-labor portion. Tables 8-10 of the proposed rule provide a hypothetical rate calculation to illustrate the methodology including the wage index adjustment and case mix adjustment.

The change to the labor share and wage index is required by law to be budget neutral. CMS meets this requirement by multiplying each of the components of the unadjusted federal rates by

[2] See https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf

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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, CMS uses the same FY 2025 claims utilization data for both the numerator and denominator of this ratio. The proposed budget neutrality factor for FY 2027 is 0.9987.

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

CMS proposes to continue using an administrative presumption that beneficiaries who are correctly assigned one of the designated case-mix classifiers on the 5-day Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date for that assessment. CMS notes that 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 using the existing administrative criteria.

In the 2019 SNF PPS final rule, CMS finalized the designation of the classifiers for purposes of applying the administrative presumption under the PDPM. This information is posted on the SNF PPS website in the paragraph entitled "Case Mix Adjustment".[3]

CMS stresses 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. For example, the presumption would not apply in a situation 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. Further, CMS will do careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the assessment reference date of the initial Medicare assessment.

B. Consolidated Billing

The consolidated billing requirements for SNFs are reviewed, including billing for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a non-covered stay. CMS also reviews the specific exclusions from that requirement that remain separately billable, including a number of "high cost, low probability" services identified by Healthcare Common Procedure Coding System (HCPCS) codes, within five categories:

- Chemotherapy items;
- Chemotherapy administration services;
- Radioisotope services;
- Customized prosthetic devices; and
- Blood clotting factor used for treatment of hemophilia and other blood disorders along with items and services related to the furnishing these products.

[3] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html

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The rule indicates that the codes targeted for exclusion from consolidated billing represent events that could have significant financial impacts because their costs far exceed SNF PPS payments. **Commenters can identify specific HCPCS codes in any of these five service categories** (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices and blood clotting factor) representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. CMS may consider excluding a particular service if it meets the criteria for exclusion: it must be included in the five categories and also must meet criteria as high cost and low probability in the SNF setting.[4]

If CMS identifies any new services that actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, it will identify these additional excluded services by means of the HCPCS codes that are in effect as of October 1, 2025. The latest list of excluded codes can be found on the SNF Consolidated Billing website.[5]

C. Payment for SNF-level Swing-bed Services

CMS discusses the statutory requirement that critical access hospitals (CAHs) continue to be paid on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement and that all non-CAH swing-bed rural hospitals continue to be paid under the SNF PPS. As discussed in the FY 2019 SNF PPS final rule, revisions were made to the swing-bed assessment in order to support implementation of PDPM. The latest changes in the Minimum Data Set (MDS) for swing-bed rural hospitals can be found at the SNF PPS website.

IV. Other SNF PPS Issues

A. Technical Updates to PDPM ICD-10 Mappings

1. Background

ICD-10 codes are used in various components of the PDPM, including assigning patients to clinical categories. The ICD-10 code mappings and lists used under PDPM, including proposed changes discussed below, are available on the PDPM website.[6]

The ICD-10 codes are updated each year in June and become effective October 1 of the same year. In the FY 2020 SNF PPS[7], CMS outlined the process it uses to maintain and update ICD-10 code mappings and lists associated with the PDPM and the SNF Grouper software. Beginning with the FY 2020 updates, nonsubstantive changes to the ICD-10 codes would be applied through the subregulatory process and substantive revisions would be proposed and finalized through notice and comment rulemaking.

[4] See the FY 2001 final rule (65 FR 46790) for discussion of these criteria, which are tied to the Conference Report discussion of section 103(a) of the Balanced Budget Reduction Act (P.L. 106-113); (H.R. Rep. No. 106-479 at 854 (1999) (Conf. Rep.)).
[5] https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling
[6] PDPM Website is available at https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model
[7] 84 FR 38750

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- Nonsubstantive changes are changes that are necessary to maintain consistency with the most current ICD-10 medical code data set.
- Substantive changes are changes that go beyond the intention of maintaining consistency with the most current ICD-10 medical code data set. Changes to the assignment of a code to a comorbidity or other changes that amount to a change in policy would be a substantive change.

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

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

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

As noted previously, PDPM is designed to classify beneficiaries based on clinical characteristics and service needs associated with resource use to determine appropriate Medicare payment. PDPM case-mix groups (CMGs) are designed to capture differences in resource needs across patient acuity groups. Changes in case-mix over time can be assessed by examining changes in the distribution of CMGs, by using a numerical representation, or Case-Mix Index (CMI). An increase in the CMI, for example, indicates higher reported patient acuity and higher expected resource needs.

CMS provides a description of its analytical framework for examining whether there has been case-mix creep (or increases in the CMI) under the PDPM. This is a "Nominal Change" or does not reflect real change in patient acuity and may indicate case-mix upcoding. For a detailed description of the analytic frameworks, including the study period, data sources, and regression setup, CMS refers readers to https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research.

CMS provides a summary of its quantification of case-mix creep in Table 11 (reproduced below) by the PDPM component-level adjustment factors (i.e., PT, OT, etc.,) and overall. 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

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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)

CMS requests information and comments on its approach to identify and address case-mix creep:

- 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.

C. IPPS Wage Index

For FY 2027, CMS proposes to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the SNF wage index. While CMS continues to believe that this data is an appropriate source of wage index information to estimate costs per day, CMS believes it is important to routinely assess whether more recent or alternative data sources may further enhance the accuracy and representativeness of its estimates. CMS notes that it 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). 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,[8] MedPAC has also discussed various conceptual approaches to Medicare wage indexes, including the use of county-level

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

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wage data from BLS with an occupational mix to construct wage indexes that are more specific to the payment setting.

CMS seeks comments on whether it should consider using alternative data sources to construct a SNF-specific wage index for potential use in future years. CMS also 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. CMS is 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.

V. SNF Quality Reporting Program (QRP)

CMS proposes to remove beginning with the FY 2028 SNF QRP two measures: (i) the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP COVID-19 Vaccine) measure and (ii) the COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date (Patient/Resident COVID-19 Vaccine) measure. The agency also proposes changes to the SNF QRP data submission deadlines beginning with the FY 2029 SNF QRP and to require the submission of Minimum Data Set (MDS) data on each resident receiving covered skilled care in a SNF, regardless of payer, beginning with the FY 2031 SNF QRP. In addition, CMS issues an RFI regarding future measure concepts.

If finalized, the estimated impact for the FY 2028 SNF QRP as a result of the removal of the HCP COVID-19 Vaccine and Patient/Resident COVID-19 measures is a reduction in annual burden hours of 185,841.58 hours across all SNFs (12.5 hours per SNF) and in annual cost of $8,398,572.45 across all SNFs ($564.88 per SNF).[9] If finalized, the estimated impact for the FY 2031 SNF QRP as a result of the proposed requirement for SNFs to submit MDS data on all residents is an increase in annual burden hours of 1,001,719.4 hours across all SNFs (67.38 hours per SNF) and in annual cost of $88,046,037 across all SNFs ($5,921.86 per SNF).[10]

CMS invites public comment on the proposals.

A. Background and Statutory Authority

The SNF QRP is authorized under section 1888(e)(6) of the Act and is a pay-for-reporting program.[11] SNFs submit specified data elements and quality measure data for each resident using the SNF resident assessment instrument known as the MDS. Completed assessments are sent to CMS through the Internet Quality Improvement & Evaluation System (iQIES). Freestanding SNFs, SNFs affiliated with acute care hospitals, and all non-CAH swing bed rural hospitals must meet resident assessment and quality data reporting requirements or be subject to a 2.0 percentage point reduction in the SNF PPS annual update factor.

[9] Estimated Impacts for the FY 2028 SNF QRP are shown in Table 26 of the rule.
[10] Estimated Impacts for the FY 2031 SNF QRP are shown in Table 27 of the rule.
[11] Program requirements are codified at §413.360.

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B. General Considerations Used for Selection of Measures

CMS refers readers to the FY 2016 SNF PPS final rule (80 FR 46429 through 46431) for considerations CMS uses for selecting quality, resource use, and other measures.[12]

The table below (Table 12 reproduced from the proposed rule with minor modifications) shows the current 15 quality measures adopted for the SNF QRP. No measures are being proposed for adoption.

Quality Measures Currently Adopted for the SNF QRP	
Short Name	**Measure Name & 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
TOH-Provider	Transfer of Health Information to the Provider – PAC Measure
TOH-Patient	Transfer of Health Information to the Patient – PAC Measure
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine*	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Data Source: 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)
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
Data Source: National Healthcare Safety Network (NHSN)	
HCP COVID-19 Vaccine*	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

[12] More information about SNF QRP measures is available on the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.

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Quality Measures Currently Adopted for the SNF QRP	
Short Name	**Measure Name & Data Source**
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

* CMS proposes removal of these two measures in the proposed rule.

C. Proposal to Remove HCP COVID-19 Vaccine Measure Beginning with the FY 2028 SNF QRP

In the FY 2022 SNF PPS final rule, CMS adopted the HCP COVID-19 Vaccine measure into the measure set. The measure requires SNFs to report the COVID-19 vaccination status of HCP through the National Healthcare Safety Network (NHSN).

CMS proposes, beginning for the FY 2028 SNF QRP, to remove this measure under measure removal factor 3, which provides for removal of a measure that does not align with the current clinical guidelines or practice.[13] Specifically, the latest CDC COVID-19 vaccination recommendations are based on individual-based decision-making, where there is not a default decision to vaccinate for a defined population. Therefore, CMS describes that both receipt and nonreceipt of the vaccination would be consistent with the latest recommendations. In contrast, the guidance that had been in place when the measure had been finalized provided for well-defined parameters for receiving the vaccination.

If the proposal is finalized, facilities would not need to report CY 2026 HCP COVID-19 Vaccine measure data to meet the SNF QRP requirements for the FY 2028 payment determination. Any 2026 measure data received by CMS would not be used for SNF QRP compliance or public reporting.

CMS has already removed this measure from the Hospital Inpatient Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, the Ambulatory Surgical Center Quality Reporting Program, the Hospital Outpatient Quality Reporting Program, and the Inpatient Rehabilitation Facility Quality Reporting Program.

D. Proposal to Remove Patient/Resident COVID-19 Vaccine Measure Beginning with FY 2028 SNF QRP

In the FY 2024 SNF PPS final rule,[14] CMS adopted the Patient/Resident COVID-19 Vaccine measure beginning for the FY 2026 SNF QRP. The measure is an assessment-based process measure that reports the percentage of stays in which residents in a SNF are up to date on their COVID-19 vaccinations according to the latest CDC guidance. At the time the measure was adopted, CDC COVID-19 vaccination guidance specified population-level vaccination recommendations for older adults and high-risk groups. However, the latest CDC vaccination recommendations are based on individual-based decision-making without a default decision to vaccination for a defined population. Similar as in the proposal for the removal of the HCP

[13] See section 413.360(b)(2) of title 42, CFR, for factors used to evaluate whether a measure should be removed from the SNF QRP.
[14] 88 FR 53526-53265.

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COVID-19 Vaccine measure, CMS describes that under the new recommendations both vaccination and non-vaccination may reflect "up to date" status.

Therefore, CMS proposes to remove, beginning with the FY 2028 SNF QRP, the Patient/Resident COVID-19 Vaccine measure from the SNF QRP under measure removal factor 3 (the measure does not align with current clinical guidelines or practice). If finalized, SNFs would no longer be required to collect and submit the measure data to CMS beginning with residents discharged on or after October 1, 2026. CMS proposes to remove the Resident's COVID-19 Vaccination is Up to Date data element from the MDS effective 1, 2027, because CMS states it is not technically feasible to remove it sooner, but the data element would not be required beginning with residents discharged on or after October 1, 2026.

CMS has already removed this measure from the Home Health Quality Reporting Program and the Inpatient Rehabilitation Facility Quality Reporting Program.

E. RFI: SNF QRP Quality Measure Concepts under Consideration for Future Years

CMS seeks input on the importance, relevance, appropriateness, and applicability of quality measure concepts related to advance care planning for the SNF setting. CMS describes that advance care planning facilitates shared decision-making by documenting resident preferences and furthering care consistent with goals throughout care transitions. CMS states that it will prioritize evidence-based outcome measures that promote person-centered care practices.

F. Form, Manner, and Timing of Data Submission Under the SNF QRP[15]

1. Proposal to Revise SNF QRP Data Submission Deadlines Beginning with FY 2029 SNF QRP

CMS is required by statute to publicly report the performance of SNFs on the SNF QRP measures and to provide confidential feedback reports to SNFs on their performance before making it public. The Secretary has discretion (per statute) to specify the timeframe for SNFs to submit data required for the SNF QRP.[16] Currently, SNFs have approximately 4.5 months after each quarterly data collection period to submit the data and make any needed corrections to the data. There is about a 9-month lag between the end of data collection and when measures are publicly reported, and the agency states that the biggest contributor to this lag is the 4.5-month timeframe for data submission. CMS describes that a goal of public reporting under quality reporting programs is to provide consumers with the most current information in order to facilitate informed decision-making. CMS believes that the time between when data on measures are submitted and when the data are made publicly available may be too long for those purposes. In addition, SNFs have provided feedback that the measure results they receive before public reporting are not useful for quality improvement because of the delay.

CMS believes that if the data submission timeframe were reduced from its current 4.5-month timeframe to instead require data submission the 15th day of the second month after the end of the calendar quarter, the lag between the end of the data collection period and public reporting

[15] Regulations on the policies for reporting data for the SNF QRP are under 42 CFR 413.360(b).
[16] Section 1888(e)(6)(B) of the Act.

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could be reduced by up to 3 months. In the FY 2026 SNF PPS proposed rule, CMS sought input on the potential future reduction of the submission deadline from 4.5 months to 45 days.

Therefore, CMS is now proposing that, beginning with the FY 2029 SNF QRP, SNFs would be required to complete data submissions and make corrections, as necessary, to their MDS assessment data and CDC NHSN data not later than the 15th day of the second month after the end of the calendar quarter, except if such 15th day falls on a Friday, weekend, or Federal holiday the deadline would be delayed until the next business day. The proposed data submission deadline is approximately within 45 days of the end of the quarter. According to an analysis conducted by CMS on the potential impact of shortening the data submission timeframe, using 2024 data, 97.18 percent of all Minimum Data Set (MDS) assessments were submitted within a 45-day period. According to another analysis conducted by CMS on the potential impact of shortening the data submission timeframe, using 2025 data, 95 percent of all CDC NHSN data were submitted by SNFs within a 45-day period.

For the FY 2029 SNF QRP, CMS proposes for MDS assessment data the data submission deadlines that are shown in the table below (reproduced from Table 13 in the rule) and the agency proposes that similar calendar year data submission deadlines would apply for future years.

Table 13: Proposed Data Collection Timeframe and Data Submission Deadlines for MDS Assessment Data Affecting 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
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

The two CDC NHSN measures included in the SNF QRP are the COVID-19 Vaccination Coverage among HCP measure and Influenza Vaccination Coverage among HCP measure. The COVID-19 Vaccination Coverage among HCP measure is being proposed for removal beginning with the FY 2028 SNF QRP (as discussed in section VI.C of the summary). The proposed deadline for data submission for the Influenza Vaccination Coverage among HCP measure for the FY 2029 payment determination would be May 15, 2028 for the data collection period of October 1, 2027 through March 31, 2028. This would mean there would be no change in the deadline for the Influenza Vaccination Coverage measure since the previously finalized data submission date is already May 15. The proposed data collection timeframe and submission deadlines for the CDC NHSN measures for the FY 2029 SNF QRP are shown in table 14 in the rule.

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2. Proposal to Require MDS Data Submission on all SNF Residents Beginning with the FY 2031 SNF QRP

a. Background

The SNF QRP currently requires MDS data submission for only Medicare FFS residents. CMS describes how it has received feedback from interested parties that quality measures in the SNF QRP should be calculated using data collected from all SNF residents, regardless of a resident's payer. CMS previously proposed in the FY 2020 SNF PPS rule to expand the collection and submission of MDS data to all SNF residents regardless of payer. The agency did not finalize its proposal, but it describes how it has since worked to address feedback it had received in response to its proposal, including by gathering additional feedback. The agency describes how under the current MDS data submission requirements, given the increasing percentage of Medicare Advantage enrollees (estimated to be 54 percent of all Medicare beneficiaries in 2025), the majority of Medicare beneficiaries will not be included in the SNF QRP.

Further, the agency believes there are benefits to aligning data submission practices across CMS programs and reviews its quality reporting programs (QRPs) that currently use data submission on all patients regardless of payer, including under the Home Health QRP, Inpatient Rehabilitation Facility QRP, Long-Term Care Hospital (LTCH) QRP, and Hospice QRP. Also, eligible clinicians participating in the Merit-based Incentive Payment System (MIPS) who submit quality measure data on qualified clinical data registry measures, MIPS clinical quality measures, or electronic clinical quality measures are required to submit the data on a specified percentage of patients regardless of payer. In addition, CMS believes that requiring submission of MDS data on all SNF residents could support the exchange of information between SNFs and other providers, which could facilitate coordinated care, continuity in care planning, and discharge care planning.

CMS notes that it would not use MDS data from non-Medicare FFS residents to update the payment rates used under the SNF PPS.

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

Unlike in other settings for which data on all patients regardless of payer are used, the MDS data required for submission in the SNF setting are required for reasons other than just quality reporting and Medicare payment. Nursing homes that are Medicare certified, Medicaid certified, or both, must conduct initial and periodic MDS assessments for both long-term residents and short-term residents in a rehabilitative program. Also, data submitted in MDS assessments are used by many State Medicaid payment and quality programs. CMS discusses how it took these considerations into account for formulating the following specific parts of its proposed policy to require submission of MDS data on all residents.

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Defining Skilled Services. CMS proposes that SNFs would submit MDS data on all SNF residents regardless of payer when all of the following four criteria[17] are met:

- The resident is admitted to the SNF for covered skilled nursing services or skilled rehabilitation services, i.e., 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).
- 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 the resident's illness or injury (i.e., 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.

Identifying Resident Population for Submission of MDS Data. Residents can be admitted to a SNF for short-term skilled care or long-term services and supports. Long-term residents may have changes in the level of care they require, such as changing from non-skilled to skilled without (or instead of) a hospitalization. CMS describes the options of whether the resident population for submission of MDS data under the proposed policy should include those admitted after an inpatient stay for short term skilled services or also long-term residents who develop a need for skilled services and receive those services without first being discharged to a hospital.

CMS proposes to require submission of MDS data on residents admitted or readmitted for covered skilled services regardless of payer and to not require such data submission for long-term residents residing in the SNF who develop the need for skilled services without leaving the facility. Under this proposed policy:

- Long-term residents who are discharged from the facility and are subsequently readmitted for covered skilled care would require the submission of MDS data (unless the services are not Medicare-covered).
- Long-term residents who take a leave of absence[18] and return to the facility requiring skilled care would not require a skilled care admission assessment or submission of MDS data.
- Short-term residents who were admitted for covered skilled care, left the facility, and returned to the same facility requiring skilled services before the end of the interruption period[19] would not require a new MDS assessment if the services remained skilled and were covered because the return stay is considered a continuation of the previous stay for purposes of the SNF QRP.

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[17] The proposal is based on a modified version of the four factors used for determining when care in a SNF is covered by Medicare Part A, as specified in the Medicare Benefit Policy Manual (MBPM) (100-2), Chapter 8, §30, available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf.
[18] A leave of absence is a temporary home visit of at least one night, therapeutic leave of at least one night, or hospital observation stay less than 24 hours (without admission).
[19] The interruption period is a 3-day period during which the resident leaves the facility, starting with the day of discharge and including the two immediate subsequent days.

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c. Proposal to Require MDS Data Submission on all SNF Residents Regardless of Payer for SNF QRP

CMS proposes, beginning with the FY 2031 SNF QRP, to require submission of MDS data on each resident receiving covered skilled care in a SNF, regardless of payer. For the FY 2031 SNF QRP, submission of this data would be required beginning with residents admitted on October 1, 2029. Starting in CY 2030, SNFs would need to submit data for the entire CY beginning for the FY 2032 SNF QRP.

Data on non-Medicare FFS SNF residents would be required to be submitted at admission and discharge using the Nursing Home PPS (NP) and Nursing Home Part A PPS Discharge (NPE) assessments and corresponding swing bed assessments (SP and SD) in use at the time of data collection.

The annual payment update applicable to a SNF for an FY is reduced by 2 percentage points if the SNF does not submit required data. Current regulations require 90 percent of MDS assessments that SNFs submit to contain 100 percent of the required data. CMS is proposing that the MDS data SNFs submit under its proposal for all SNF residents would be used to calculate SNF QRP compliance. The data submission deadline proposal discussed in section VI.F.1 of the summary to shorten the data submission deadline would apply to this proposed expanded MDS data requirement.

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

In sections VI.C and VI.D of the proposed rule, CMS proposes to remove the HCP COVID-19 Vaccine measure and the Patient/Resident COVID-19 Vaccine measure, respectively, beginning with the FY 2028 SNF QRP.

If the removal of the HCP COVID-19 Vaccine measure is finalized, CMS proposes that a SNF's data on that measure would be reported for the last time with the October 2026 Care Compare refresh on Medicare.gov, based on data from quarter 4 of 2025.

If the removal of the Patient/Resident COVID-19 Vaccine measure is finalized, CMS proposes that reporting the data for the Resident's COVID-19 Vaccination is Up to Date data element would be voluntary beginning October 1, 2026 and the measure data would be publicly reported for the last time with the October 2026 Care Compare refresh on Medicare.gov, based on data from quarter 4 of 2025.

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VI. Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

A. Background

The SNF VBP Program is authorized under section 1888(h) of the Act and awards incentive payments to SNFs to reward better quality of care, value, and outcomes.[20] It was implemented for discharges beginning in FY 2019 and applies to all SNFs paid under the SNF PPS: freestanding, affiliated with acute care facilities, and non-CAH swing-bed rural facilities.

Currently, the SNF VBP Program withholds 2.0 percent of the payments that would be made to SNFs and redistributes approximately 60 percent of the money withheld for redistribution based on their measure performance. Specifically, amounts redistributed are delivered by applying a value-based incentive adjustment at the individual claim-level to each SNF's adjusted FY Federal per diem rate. The remaining 40 percent is returned as savings to the Medicare program, minus funds used for adjustments made according to low-volume facility policies. For the FY 2027 SNF VBP program year, 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 the measure minimum requirement will be excluded from the Program and receive their adjusted Federal per diem rate for the fiscal year.

In this section, CMS provides the estimated numerical performance standards for the FY 2030 program year for the SNF WS PPR measure and the DTC PAC SNF measure and the estimated numerical performance standards for the FY 2029 program year for the remaining measures. The agency proposes to modify the snapshot dates used for purposes of the SNF VBP review and corrections process to align with the agency's proposal to revise the SNF QRP's submission deadline for MDS assessment data.

CMS estimates that to maintain the overall 60 percent payback percentage, approximately $305.11 million will be redistributed (of the estimated $508.52 million in withheld funds) in value-based incentive payments to SNFs in FY 2027, meaning that the SNF VBP Program is estimated to result in $203.41 million in savings to the Medicare program in FY 2027.

Proposals in this section are open to comment.

B. SNF VBP Program Measures

Section 1888(g) mandates the adoption of certain measures (the SNF Readmission Measure[21]), and section 111 of CAA, 2021 amended section 1888(h) of the Act to permit CMS to add up to 9 measures (in addition to the SNF Readmission Measure) to the SNF VBP Program, as the agency determines to be appropriate, including measures of functional status, patient safety, care

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[20] More information on the SNF VBP Program can be found on the CMS web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page. The SNF VBP Program regulations are at 42 CFR 413.337(f) and 413.338.

[21] Currently the SNF Readmission measure is the SNFRM, which is to be replaced by the SNF WS PPR measure, beginning with the FY 2028 program year.

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coordination, or patient experience. Table 15 in the rule lists the measures that have been adopted so far for the SNF VBP Program and their status for the FY 2027 through FY 2030 program years.

SNF VBP Program Measures and Timeline for Inclusion in the Program (Based on Table 15 of the Rule)

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

X = measure is included

CMS is not proposing any changes to the measure set. The agency is, however, proposing a technical update to a reference within the codified measure selection, retention, and removal policy that it finalized in the FY 2025 SNF PPS final rule. The update would change the cross-reference under §413.338(k)(3) for details on that codified selection, retention, and removal policy to reference §413.338(k)(2) instead of §413.338(l)(2).

C. SNF VBP Performance Standards

1. Estimated Performance Standards for FY 2029 Program Year

CMS adopted the final FY 2029 performance standards for the DTC PAC SNF measure and SNF WS PPR measure in the FY 2026 SNF PPS final rule (90 FR 37348 through 37349). In this rule it provides estimated numerical performance standards for the remaining measures applicable for the FY 2029 program year in Table 16 of the rule, and the agency will provide the final numerical performance standards for the FY 2029 program year for these measures in the FY 2027 SNF PPS final rule.

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Table 16: Estimated FY 2028 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

2. Estimated Performance Standards for FY 2030 Program Year

The measurement window for the SNF WS PPR and DTC PAC SNF measures is 2 years, while the measurement window for the remaining measures is one year. Therefore, CMS provides the estimated numerical performance standards for the FY 2030 program year for the SNF WS PPR measure and the DTC PAC SNF measure in Table 17 of the rule. It 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, and will provide the estimated numerical performance standards for the remaining measures for the FY 2030 program year in the FY 2028 SNF PPS proposed rule.

Table 17: Estimated FY 2029 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 Update to SNF VBP Review and Corrections Process

CMS walks through the SNF VBP review and corrections process.[22] The process includes two phases. Under phase one, SNFs may submit requests for corrections to measure results contained in the baseline period and performance period quality measure quarterly reports. The underlying data contained in those reports are not subject to review and corrections during this process. The measure results are calculated using data current as of specified dates for each measure (referred to as snapshot dates). Data used to calculate a measure must be corrected before the specified snapshot date in order for the correction to be reflected in the quarterly confidential feedback reports. Under phase two, SNFs may submit requests for corrections to the SNF performance score and ranking contained in the performance score report.

Application of the phase one review and corrections process applies to SNF VBP program measures calculated using MDS data.[23] Beginning with the FY 2027 SNF VBP program year, the Falls with Major Injury (Long-Stay) and DC Function measures (both of which are calculated using assessment data report on the MDS 3.0) are included in the program. The snapshot date for both measures is the February 15th that is 4.5 months after the last day of the applicable baseline or performance period, except in the case the deadline falls on a Friday, weekend, or Federal holiday, the deadline is then delayed until the next business day.

[22] The review and corrections process is codified under §413.338(f)(2).
[23] Application of phase one was finalized in the FY 2025 SNF PPS final rule (89 FR 64136).

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To align with the agency's proposal to revise the SNF QRP's submission deadline for MDS assessment data (discussed under section VI.F.1 of the summary), CMS proposes to change the snapshot date for these measures to instead be the 15th day of the second month after the last day of the applicable baseline or performance period, except if that 15th day falls on a Friday, weekend, or Federal holiday, the snapshot date would be delayed until the next business day.

E. SNF VBP Extraordinary Circumstances Exception (ECE) Policy

In the FY 2025 SNF PPS final rule, CMS updated and codified its ECE policy. Other updates were made in the FY 2026 SNF PPS final rule that changed regulatory section references. These updates did not make needed conforming changes to references within the ECE policy. Therefore, CMS is now proposing a technical change to its ECE policy that would update the references under §413.338(l)(3), which currently incorrectly refer to §413.338(m)(2) and (4), to instead reference §413.338(l)(4) and (2).

VII. Economic Analyses

CMS estimates that under the proposed rule in FY 2027, SNFs would experience an increase of $888 million in payments from the update to the payment rates, or an average increase of 2.4 percent across all SNFs. CMS notes that these impact numbers do not incorporate the SNF VBP reductions that are estimated to reduce aggregate payments to SNFs by $203.41 million.

Table 25 of the proposed rule (reproduced below) shows the estimated impact of the proposed rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the updates to the payment rates and the budget neutral updates to the wage index data. The combined effects of all of these changes vary by specific type of providers and by location. For example, CMS estimates that due to the changes in this proposed rule, payment rates for SNFs in rural areas would increase by 2.7 percent overall compared with 2.4 percent for SNFs in urban areas.

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%

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Table 25: Impact to the SNF PPS for FY 2027			
Impact Categories	**Number of Facilities**	**Update Wage Data**	**Total Change**
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%

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Appendix: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes

CMS notes that under PDPM, providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim in order to bill for covered SNF services. The first character of the HIPPS code 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 in the proposed rule (recreated below) show the case-mix adjusted federal rates and associated indexes for PDPM groups for urban and rural SNFs, respectively. In each table, Column 1 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) that is 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.

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	-	-

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PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
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 6: 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	-	-

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