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-F] Final Rule Summary

On July 31, 2026, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (91 FR 48588) a final 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 final rule also includes a summary of comments received from a request for information (RFI) on updating the Patient Driven Payment Model (PDPM) to address case-mix upcoding and improve payment accuracy. In addition, CMS discussed comments received 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 QRP, CMS finalizes its proposal 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 finalizes 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 summarizes comments received on a RFI regarding a future measure concept on advanced care planning. For the SNF VBP, CMS provides final numerical performance standards for specified measures for the FY 2029 and 2030 program years. The agency also finalizes modifying the snapshot dates used for purposes of the SNF VBP review and corrections process to align with the agency's revised SNF QRP's submission deadline for MDS assessment data.

CMS estimates that the overall impact of the final rule will be an increase of $882.74 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.

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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 services.

II. SNF PPS Rate Setting Methodology and FY 2027 Update

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

Summary of Key Data under SNF PPS for FY 2027	
Market basket update factor	
Market basket increase	+3.3%
Forecast error adjustment for FY 2025*	+0.0%
Total Factor Productivity (TFP) adjustment	-0.9%
Net TFP-adjusted update	**+2.4%**
Wage index budget neutrality adjustment	0.9989
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 finalizes a market basket increase for FY 2027 of 3.3 percent based on the third quarter 2027 forecast from IHS Global Insight, Inc. (IGI), with historical data through the first quarter of 2026. 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 final 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 0.9 percentage points, based on the updated forecast. 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 TFP for the period ending September 30, 2027, based on IGI's forecast.

Thus, the resulting productivity-adjusted FY 2027 SNF market basket increase is equal to 2.4 percent (market basket increase of 3.3 percent minus the 0.9 percentage point productivity adjustment).

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

CMS also continues 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 productivity-adjusted update, CMS finalizes FY 2027 unadjusted federal rates for each component of the payment for urban and rural areas that are shown in the tables 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.

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

Final FY 2027 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$77.46	$88.30
Occupational Therapy	$72.10	$81.10
Speech-Language Pathology	$28.93	$36.44
Nursing	$135.02	$129.00
Non-Therapy Ancillaries	$101.87	$97.33
Non-case mix adjusted	$120.91	$123.15

Selected Comments/Responses. There were multiple comments that expressed concerns about missed forecasts and whether the market basket is accurately capturing inflation and the severity of workforce-related cost pressures. This included a suggestion to implement more responsive and dynamic mechanisms to address inflation in real-time or near real-time, such as a prospective adjustment. CMS states that while it recognizes the appeal, it believes the use of such approaches could introduce more variable and unstable updates during periods of economic volatility. It also notes that a 2-year lag is necessary for the forecast error adjustment because historical data for the current FY are not available until after the following year's update is determined.

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 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 final rule (reproduced in the appendix to this summary) show the final 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 finalizes its proposal 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 will 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.

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 will continue to use the same policy it has used in prior years. For rural areas without hospitals, CMS will 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 will 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 will 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).

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

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 final SNF labor-related share is 72.0 percent, compared to a FY 2026 final labor-related share of 71.9 percent. Table 7 in the final rule summarizes the labor-related share for FY 2027 (based on the IGI second quarter 2026 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 final 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 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 final budget neutrality factor for FY 2027 is 0.9989.

Selected Comments/Responses. Multiple commenters recommended that CMS implement a direct-care spending standard for Medicare SNF payments of at least 85 percent, and to limit all non-labor related costs to 15 percent of payments, in order to allocate Medicare funds to beneficiary treatment and services rather than administrative costs and profit margins. CMS stated that it appreciated commenters' suggestion and would take this under consideration during future rulemaking cycles.

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

CMS finalizes its proposal 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]

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

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.

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. CMS noted in the proposed rule that 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 a specific date (in this case, October 1, 2024). The latest list of excluded codes can be found on the SNF Consolidated Billing website.[5]

Selected Comments/Responses. Commenters requested that CMS add TECVAYLI® / teclistamab-cqyv, J9380 and TALVEY® / talquetamab-tgvs, J3055 to the SNF consolidated billing exclusion list under the chemotherapy items category. Commenters stated that the drugs are used for multiple myeloma, are rarely administered in SNFs, and have high weekly acquisition costs that could create access barriers if included in the SNF bundle. Commenters

[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

also requested that CMS exempt all chemotherapy drugs above a certain low dollar threshold, rather than identify each excluded drug by HCPCS code. In response, CMS notes that the statute authorizes CMS to identify excluded chemotherapy items through HCPCS code-level designations rather than through a broad cost-based exemption. Accordingly, CMS states it will review and analyze the HCPCS codes J9380 and J3055 for consideration to be added or omitted from the SNF consolidated billing exclusion list and any future chemotherapy items would need to be evaluated at the HCPCS level.

CMS also received a request to add HCPCS codes L1940, L1960, L1970, L3905, and L3906 to the SNF consolidated billing exclusion list. The commenters stated that these specialized orthotic devices support residents with neurological, orthopedic, spinal, and rehabilitative needs. CMS states in its response that these HCPCS codes describe orthotic devices rather than customized prosthetic devices and thus do not fall within the statutory category of items that CMS may designate for exclusion from SNF consolidated billing through this process.

Commenters also requested that CMS remove CPT code 97610 from the "sometimes therapy" designation and remove the code from SNF Consolidated Billing File 4, while maintaining it on File 1 as an excluded physician service. Commenters stated that CPT code 97610 describes low-frequency, non-contact, non-thermal ultrasound wound therapy and involves wound assessment, treatment planning, dressing decisions, and clinical judgment typically furnished by physicians, nurse practitioners, or physician assistants. Commenters stated that physical therapists bill only a small share of services reported under this code and that the "sometimes therapy" designation has caused claims processing confusion and inappropriate denials. CMS states in response that to the extent CPT code 97610 is furnished and billed as a physician professional service, it is not subject to SNF consolidated billing. With respect to the designation of the code as "sometimes therapy", CMS states that this designation is not itself a determination under the high-cost, low-probability consolidated billing exclusion categories. CMS states that it will consider the commenters' concerns as part of its ongoing review of the SNF consolidated billing files and related claims processing instructions.

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. CMS did not receive any public comments on payment for SNF-level swing-bed services.

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 the 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.

- 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. 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.

Selected Comments/Responses. Commenters had several suggestions for revisions to the PDPM ICD-10 code mappings.

- Requested that ICD-10 codes Z51.A (Encounter for Sepsis Aftercare) and F01.50 (Vascular Dementia) be reclassified from the "Return to Provider" clinical category to "Medical Management". CMS stated that it would take this under consideration during future rulemaking.
- Requested that ICD-10 codes R62.7 (Adult Failure to Thrive) and M62.81 (Muscle Weakness [Generalized]) be reclassified from the "Return to Provider" clinical category to "Medical Management" to overcome an operational gap. CMS disagrees and believes these codes lack specificity and should remain as "Return to Provider".

[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

- Recommended that the SLP comorbidity ICD-10 code list be expanded to include additional dysphagia codes to be used in combination with clinically related diagnoses. These include the following dysphagia codes: R13.11, R13.12, R13.13, R13.14, and R13.19. They added that inclusion of these codes would more accurately recognize residents with clinically significant swallowing impairment and further align SLP comorbidity classification with skilled service needs. CMS states that it will take this into consideration during future rulemaking cycles.

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. The primary focus of the analysis is determining whether "Nominal Change" occurred or 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. 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 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 requested 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.

Selected Comments/Responses. Many commenters, including MedPAC, expressed support for the agency's efforts to address case-mix creep, noting that current trends suggest coding practices are being utilized to maximize reimbursement rather than meet genuine patient needs. Other commenters opposed the implementation of any future payment reductions related to case-mix creep adjustment. These stakeholders asserted that the rise in the reporting of specific conditions reflects the intended design of the PDPM, which they believe has resulted in improved clinical documentation practices, enhanced interdisciplinary collaboration, and more comprehensive identification of conditions that were previously underreported. Several providers believe that the shift in SNF patient acuity is also related to acute-care hospitals discharging increasingly complex and medically fragile patients to post-acute settings. Other concerns included the study periods evaluated, particularly the inclusion of data from the COVID-19 public health emergency (PHE) and periods prior to the parity adjustment.

Comments from provider organizations cautioned that these specific reductions are misaligned with the intensive nursing hours, dietary interventions, and costly pharmaceutical therapies required by the SNF population. MedPAC recommended implementing a component-specific approach to case-mix creep adjustment, stating that such a methodology may better target localized coding practices compared to a uniform reduction. However, other commenters urged the agency to proceed cautiously and transparently, and recommended deferring any policy changes until additional, independently validated data are available. Several commenters also requested that if any adjustment is ultimately finalized, it should be phased in over multiple fiscal

years with ample advance notice and accompanied by transparent facility-level impact analyses to mitigate potential disruptions in beneficiary access to care.

CMS thanks commenters for their responses and states it will take these comments under advisement as it considers proposed adjustments in future rulemaking.

C. IPPS Wage Index

For FY 2027, CMS will 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 wage data from BLS with an occupational mix to construct wage indexes that are more specific to the payment setting.

CMS sought 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 sought 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.

Selected Comments/Responses. Many commenters expressed broad support for development of a SNF-specific wage index as an alternative to the current IPPS wage index. Commenters noted that the current reliance on the IPPS wage index fails to accurately reflect the unique labor costs, occupational mix, and workforce structures of SNFs. Despite this general support for a SNF-specific wage index, several commenters highlighted the need for the agency to proceed with caution given the potential financial impacts on providers from a budget neutral transition to a SNF-specific wage index. Further, if CMS adopts a SNF-specific wage index, commenters urged CMS to phase-in the implementation of such a change and maintain protective measures, such as the current 5-percent cap on year-over-year wage index reductions.

Comments were split on the underlying data sources that could be used to develop the SNF-specific wage index. A few commenters, including MedPAC, supported the potential use of Bureau of Labor Statistics Occupational Employment and Wage Statistics (BLS-OEWS) data,

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

highlighting substantial benefits such as the data being publicly available, highly current, and the potential to substantially reduce the administrative burden on both the agency and providers compared to auditing cost reports. Others opposed the use of BLS data noting that it aggregates nursing facility staff with non-healthcare employers in the region; fails to capture total compensation, such as crucial health benefits and highly expensive contract or agency labor fees; excludes hospital-based nursing homes; and lacks the rigorous, transparent review and correction processes. Instead, some commenters recommended the agency prioritize facility-specific Medicare cost report data, adding that despite the administrative burden to audit the data, it provides a much more precise reflection of the actual economic pressures facing Medicare-participating providers. Other commenters recommended using the Payroll-Based Journal (PBJ) for data on staff hours, as PBJ can be verified from facilities' payment records and is already used in the Nursing Home Five-Star Program.

CMS thanks commenters for their responses and states it will take these comments under advisement as it considers development of a SNF-specific wage index in future rulemaking.

V. SNF Quality Reporting Program (QRP)

CMS finalizes its proposals 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 finalizes its proposed 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 summarizes public comments it received in response to its RFI on future measure concepts.

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 186,154 hours across all SNFs (12.5 hours per SNF) and in annual cost of $8,412,277.12 across all SNFs ($564.81 per SNF).[9] The estimated impact for the FY 2031 SNF QRP as a result of the finalized requirement for SNFs to submit MDS data on all residents and related new MDS items is an increase in annual burden hours of 1,001,719.4 hours across all SNFs (67.26 hours per SNF) and in annual cost of $88,046,037 across all SNFs ($5,911.51 per SNF).[10]

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

[9] Estimated Impacts for the FY 2028 SNF QRP are shown in Table 21 of the rule.
[10] Estimated Impacts for the FY 2031 SNF QRP are shown in Table 24 of the rule.
[11] Program requirements are codified at §413.360.

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.

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 rule with minor modifications) shows the existing 15 quality measures adopted for the FY 2027 SNF QRP.

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)	

[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.

Quality Measures Currently Adopted for the SNF QRP	
Short Name	**Measure Name & Data Source**
HCP COVID-19 Vaccine*	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

* CMS finalizes removal of these two measures in the final rule beginning with the FY 2028 SNF QRP.

C. Removal of HCP COVID-19 Vaccine Measure Beginning with the FY 2028 SNF QRP

CMS finalizes, beginning for the FY 2028 SNF QRP, its proposal to remove the HCP COVID-19 Vaccine measure[13] under measure removal factor 3, which provides for removal of a measure that does not align with the current clinical guidelines or practice,[14] as well as measure removal factor 8, which provides for removal of a measure for which the cost associated with it outweighs the benefit. Facilities will 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 data received by CMS on this measure will not be used for SNF QRP compliance or public reporting.

CMS justified the removal under removal factor 3 because the CDC COVID-19 vaccination recommendations for the 2025-2026 season use individual-based decision-making, where there is not a default decision to vaccinate for a defined population. CMS describes that both receipt and nonreceipt of the vaccination would be consistent with those recommendations. In contrast, the guidance that had previously been in place when the measure had been adopted into the measure set provided for well-defined parameters for receiving the vaccination. The U.S. District Court for the District of Massachusetts on March 16, 2026, issued a stay delaying the effective date of the ACIP committee votes made after June 11, 2025. Those votes include the 2025-2026 season COVID-19 vaccine recommendations for older adults. CMS believes the resulting uncertainly about which set of recommendations will be maintained results in the HCP COVID-19 Vaccine measure no longer yielding meaningful results.

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.

Selected Comments/Responses. Several commenters supported the proposed removal of the measure because they believe it no longer aligns with current clinical guidance, there's uncertainty about how to interpret and apply the guidance which continues to evolve, and the burden associated with reporting the measure data outweighs its value. Several other commenters opposed the proposal because they believe COVID-19 vaccination remains an important

[13] 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).
[14] 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.

infection prevention strategy, especially for SNF residents who are a particularly vulnerable population.

D. Removal of Patient/Resident COVID-19 Vaccine Measure Beginning with FY 2028 SNF QRP

In the FY 2024 SNF PPS final rule,[15] 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 2025-2026 season CDC vaccination recommendations use individual-based decision-making without a default decision to vaccinate for a defined population. Similar as in the proposal for the removal of the HCP COVID-19 Vaccine measure, CMS describes that under those 2025-2026 season recommendations both vaccination and non-vaccination may reflect "up to date" status.

CMS finalizes its proposal 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) and measure removal factor 8 (cost associated with the measure outweighs the benefit). SNFs will no longer be required to collect and submit the measure data to CMS beginning with residents discharged on or after October 1, 2026. CMS will remove the Resident's COVID-19 Vaccination is Up to Date data element from the MDS effective October 1, 2027, because CMS states it is not technically feasible to remove it sooner, but the data element will 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.

Selected Comments/Responses. Several commenters supported the proposal because of the changed CDC recommendations, the burden associated with reporting the measure, concerns with evolving definitions related to "up to date" vaccination status, and the belief that vaccination decisions reflect personal choice rather than quality of care. Other commenters opposed the proposal because they believe SNF residents are a vulnerable population and vaccination remains an important strategy to protect SNF residents from severe illness, hospitalization, and death. As in the responses to comments regarding the removal of the HCP COVID-19 Vaccine measure, CMS again notes the March 16, 2026 stay issued by the U.S. District Court for the District of Massachusetts that delays the effective date of the ACIP recommendations for older adults. The agency believes this decision results in uncertainty about which set of recommendations will be maintained and therefore also believes the Patient/Resident COVID-19 Vaccine measure no longer yields meaningful quality measure results.

[15] 88 FR 53526-53265.

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

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

In the final rule, CMS summarizes feedback it received, states it will take the feedback into consideration for future measure development efforts, but does not respond to comments.

Many commenters supported an advance care planning measure, believing it would be relevant for the SNF population, could better patient outcomes, and could facilitate care across care settings. Several commenters recommended measures and activities that should be taken before implementing a measure. A few commenters suggested including caregiver involvement in the measure framework. CMS also received comments on other future measure concepts.

F. Form, Manner, and Timing of Data Submission Under the SNF QRP[16]

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

Background. 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.[17] Under existing policy, 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 believes that the time between when data on measures are submitted and when the data are made publicly available may be too long to provide consumers with the most current information in order to facilitate informed decision-making. CMS further believes that if the data submission timeframe were reduced from its current 4.5-month timeframe to instead require data submission by 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 could be reduced by up to 3 months.

Final Action. CMS finalizes its proposal that, beginning with the FY 2029 SNF QRP (CY 2027 data submissions), SNFs will 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 will be delayed until the next business day. The finalized data submission deadline is approximately within 45 days of the end of the quarter.

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

For the FY 2029 SNF QRP, CMS finalizes for Minium Data Set (MDS) assessment data the data submission deadlines that are provided in the table below (which reflects information from Table 13 in the rule) and similar calendar year data submission deadlines will apply for future years.

Finalized 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. CMS finalizes removal of the COVID-19 Vaccination Coverage among HCP measure beginning with the FY 2028 SNF QRP (as discussed in section VI.C of the summary). The finalized deadline for data submission for the Influenza Vaccination Coverage among HCP measure for the FY 2029 payment determination will be May 15, 2028, for the data collection period of October 1, 2027, through March 31, 2028. This means there will be no change in the deadline for the Influenza Vaccination Coverage measure since the previously finalized data submission date is already May 15. The finalized 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.

Selected Comments/Responses. Several commenters supported the proposal because they believed the timely public reporting could improve beneficiary and caregiver informed decision-making. Several commenters supported the proposal but raised concerns about administrative burden and staffing challenges, especially since providers continue to experience staffing shortages. CMS does not believe the proposal adds burden for MDS coordinators or reimbursement staff, and explains that the proposal would instead shift the existing workflow from 4.5 months after each quarterly data collection period to the 15th day of the second month after the end of the quarter. Plus, CMS points to a couple analyses (mentioned also in the proposed rule) on the potential impact of shortening the data submission timeframe that indicate most data are submitted within this timeframe anyway. One analysis, using 2024 data indicated that about 97 percent of all MDS assessments were submitted within a 45-day period. Another analysis, using 2025 data, showed 95 percent of all CDC NHSN data were submitted by SNFs within a 45-day period.

Some commenters expressed concern that the timeline would not provide adequate time for facilities to validate data to identify and correct errors. CMS believes that SNFs will have enough time before the FY 2029 SNF QRP effective date to adjust workflow operations to enable such validation by the new timeframe. Other commenters recommended CMS provide resources to facilities to implement the policy. CMS refers readers to the resources and help desks on its website https://www.cms.gov/medicare/quality/snf-quality-reporting-program/help which the agency intends to update to account for this finalized policy.

2. 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 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 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 (MA) 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 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.

However, 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 in formulating the specific parts of its newly finalized policy to require submission of MDS data on all residents.

b. Final Action Expanding MDS Data Submission to All SNF Residents

CMS finalizes its proposal, 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 will be required beginning with residents admitted on October 1, 2029. Starting in CY 2030, SNFs will need to submit data for the entire CY beginning for the FY 2032 SNF QRP.

Data on non-Medicare FFS SNF residents will 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. CMS notes that it will not use MDS data from non-Medicare FFS residents to update the payment rates used under the SNF PPS. CMS also clarifies that it is not making any changes to its policies related to the *public reporting* of SNF QRP data. That is, CMS did not propose or finalize any policy related to publicly reporting SNF QRP data collected on non-Medicare patients.

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. The MDS data SNFs submit under the finalized policy for all SNF residents will be used to calculate SNF QRP compliance. The finalized data submission deadline policy discussed in section VI.F.1 of the summary to shorten the data submission deadline will apply to this expanded MDS data requirement.

Skilled Services/Care. CMS finalizes its proposal that SNFs are to submit MDS data on a resident regardless of payer when all of the following four criteria[18] are met:

- The resident is admitted or readmitted 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.

To take these factors into account, CMS finalizes its proposal 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 policy:

- Long-term residents who are discharged from the facility and are subsequently readmitted for covered skilled care will require the submission of MDS data (unless the services are not Medicare-covered).

[18] The criteria are 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.

- Long-term residents who take a leave of absence[19] and return to the facility requiring skilled care will 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[20] will 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.

c. Selected Comments/Responses

Many commenters supported the proposal, citing reasons such as the expanding MA population and the importance of accurate and comprehensive MDS data. Some commenters wanted an earlier implementation date, but CMS believes not all SNFs would be prepared to implement the policy ahead of the finalized October 1, 2029, date.

Many commenters expressed concerns about the administrative and operational challenges of expanding the MDS reporting requirements to all payers, specifically raising concerns about applying the skilled care definition to both short-term and long-term residents, proprietary guideline requirements of other payers, and workflow and technology challenges. Multiple commenters raised concerns about how the resident population for SNF QRP reporting would be defined using the skilled care definition. One point raised was that skilled coverage determinations, authorization processes, denial and appeal practices, and length-of-stay management all vary widely among MA plans and other payers. CMS responds that the definition is for identifying residents for whom an MDS would be required and that the elements of the definition are those which SNFs already use to make decisions about whether a Medicare Part A resident qualifies for a covered SNF level of care. CMS acknowledges that skilled coverage determinations vary widely among plans and payers but does not believe these differences impact the application of the definition of covered skilled services for identifying the residents for whom an MDS would be required.

Several commenters observed challenges with applying the identified criteria for Medicare/Medicaid dually eligible residents and residents receiving skill in-place services (i.e., those transitioning between custodial and skilled status). CMS clarifies the policy does not require submission of MDS data on long-term residents who become skilled in place, meaning those requiring skilled services without leaving the facility. Commenters raised questions about what happens if a resident's payer changes. CMS responds that if "the resident continued to be eligible for covered skilled services, then the SNF would complete the appropriate discharge assessment (that is, the PPS Discharge or SCD) and then complete the appropriate admission assessment (that is, the 5-day PPS or SCA)." Multiple other scenarios were raised by commenters asking for guidance as to how the requirement would be applied. For most, CMS

[19] 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).
[20] 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.

points to the four finalized criteria for applying the analysis of whether or not data submission would be triggered.

Some commenters raised concerns about differing payer requirements that may include additional MDS assessments (or may not require MDS assessments at all) and payer-specific timing requirements for submitting MDS assessments. CMS acknowledges these concerns but states it cannot control what other payers require and that it believes SNFs already have processes for managing differences in payer assessment schedules.

Other commenters expressed concern about measure validity since measures were designed, tested, validated, and adjusted using Medicare FFS populations and outcomes. CMS clarifies that it did not make any proposals for policies related to how this expanded data would be used in quality measures but will take this feedback into consideration as it evaluates the impact of the data on quality measures.

Several commenters were concerned that the expanded population and additional reporting requirements under the proposal would increase the risk of SNFs losing their annual 2-percent APU adjustment. CMS disagrees and says that it believes the policy removes workflow burden since SNFs would no longer separate out Medicare FFS beneficiaries from other residents for MDS data collection. CMS also refers to several reports available to providers to monitor their compliance, which are available within iQIES, including the SNF-Final Validation Report (FVR) and Provider Threshold Report (PTR).

In response to the many comments raised about the burden imposed by the policy, CMS explains the following about its burden estimate. First, the agency believes that new burden will occur only when the length of stay (LoS) of a non-Medicare FFS resident is less than 14 days or when such resident is discharged to a non-certified bed in the SNF. This is because SNFs are already required to complete a comprehensive admission assessment for all residents regardless of payer when the LoS is at least 14 days and to complete a discharge assessment when a resident is physically discharged from the facility. CMS' internal study finds that the average LoS is above the 14-day threshold. Second, CMS found that SNFs already combine assessments the majority of the time for Medicare FFS residents and assume they will do so for non-Medicare FFS residents. Therefore, CMS believes additional burden would be limited to assessments that are not already combined (about 23 percent of admission assessments and 30 percent of discharge assessments based on FFS resident data). The agency acknowledges that actual burden will vary across providers.

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

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

CMS also finalizes its corresponding policies ending public display of HCP COVID-19 Vaccine measure data and Patient/Resident COVID-19 Vaccine measure data after the October 2026 Care Compare refresh on Medicare.gov (which is based on data from quarter 4 of 2025).

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.[21] 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 final numerical performance standards for the FY 2030 program year for the SNF WS PPR measure and the DTC PAC SNF measure and the final numerical performance standards for the FY 2029 program year for the remaining measures. The agency finalizes its proposal to modify the snapshot dates used for purposes of the SNF VBP review and corrections process to align with the agency's finalized revision to the SNF QRP's submission deadline for MDS assessment data.

CMS estimates that to maintain the overall 60 percent payback percentage, approximately $305.39 million will be redistributed (of the estimated $508.99 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 $203.6 million in savings to the Medicare program in FY 2027.[22]

B. SNF VBP Program Measures

Section 1888(g) mandates the adoption of certain measures (the SNF Readmission Measure[23]), 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 coordination, or patient experience. Table 15 in the rule lists the measures that have been

[21] 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.
[22] Analysis of the impacts of the FY 2027 SNF VBP program is shown in Tables 28 through 30 of the rule.
[23] 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.

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 did not propose any changes to the measure set. The agency is finalizing a technical update to a reference within the codified measure selection, retention, and removal policy that it previously finalized in the FY 2025 SNF PPS final rule. The update changes 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. 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 the final numerical performance standards for the remaining measures applicable for the FY 2029 program year in Table 16 of the rule (shown below).

FY 2029 SNF VBP Program Performance Standards

Measure Short Name	Achievement Threshold	Benchmark
SNF HAI Measure	0.92102	0.94355
Total Nurse Staffing Measure	3.33606	5.98992

Nursing Staff Turnover Measure	0.44444	0.77731
Falls with Major Injury (Long-Stay) Measure	0.95522	0.99945
Long Stay Hospitalization Measure	0.99762	0.99960
DC Function Measure	0.42857	0.84522

2. 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 final 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 (shown below). The agency 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.

FY 2030 SNF VBP Program Performance Standards

Measure Short Name	Achievement Threshold	Benchmark
DTC PAC SNF Measure	0.43459	0.68006
SNF WS PPR Measure	0.85620	0.92121

D. Update to SNF VBP Review and Corrections Process

CMS walks through the SNF VBP review and corrections process.[24] 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.[25] 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 reported 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.

To align with the agency's finalized proposal to revise the SNF QRP's submission deadline for MDS assessment data (discussed under section VI.F.1 of the summary), CMS finalizes its policy 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

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

a Friday, weekend, or Federal holiday, the snapshot date will 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. CMS is now finalizing a technical change to its ECE policy that updates the references under §413.338(l)(3), which currently incorrectly refer to paragraphs (m)(2) and (m)(4) of §413.338, to instead reference paragraphs (l)(2) and (l)(4), respectively, of that section.

VII. Economic Analyses

CMS estimates that under the final rule in FY 2027, SNFs would experience an increase of $882.74 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 $203.60 million.

Table 25 of the final rule (reproduced below) shows the estimated impact 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 provider and by location. For example, CMS estimates that due to the changes in this final 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	14,894	0.0%	2.4%
Urban	10,816	0.0%	2.4%
Rural	4,078	0.3%	2.7%
Hospital-based urban	302	0.5%	2.9%
Freestanding urban	10,514	-0.1%	2.3%
Hospital-based rural	344	0.5%	2.9%
Freestanding rural	3,734	0.3%	2.7%
Urban by region			
New England	678	0.1%	2.5%
Middle Atlantic	1,427	1.4%	3.8%
South Atlantic	1,863	-0.9%	1.4%
East North Central	2,090	-0.8%	1.6%
East South Central	549	-0.9%	1.5%
West North Central	906	-0.1%	2.3%
West South Central	1,380	-0.8%	1.6%
Mountain	526	-0.5%	1.9%
Pacific	1,390	0.1%	2.5%

Table 25: Impact to the SNF PPS for FY 2027			
Impact Categories	**Number of Facilities**	**Update Wage Data**	**Total Change**
Outlying	7	1.9%	4.4%
Rural by region			
New England	112	2.1%	4.6%
Middle Atlantic	214	0.7%	3.1%
South Atlantic	526	1.6%	4.1%
East North Central	848	0.2%	2.6%
East South Central	482	-0.2%	2.2%
West North Central	938	0.7%	3.1%
West South Central	687	-1.3%	1.1%
Mountain	185	-1.8%	0.5%
Pacific	85	1.9%	4.3%
Outlying	1	-0.1%	2.3%
Ownership			
For profit	10,830	0.0%	2.4%
Non-profit	3,098	-0.1%	2.3%
Government	966	-0.5%	1.9%

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 final 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	$112.32	1.41	$101.66	0.64	$18.52	ES3	3.84	$518.48	3.06	$311.72
B	1.61	$124.71	1.54	$111.03	1.72	$49.76	ES2	2.90	$391.56	2.39	$243.47
C	1.78	$137.88	1.60	$115.36	2.52	$72.90	ES1	2.77	$374.01	1.74	$177.25
D	1.81	$140.20	1.45	$104.55	1.38	$39.92	HDE2	2.27	$306.50	1.26	$128.36
E	1.34	$103.80	1.33	$95.89	2.21	$63.94	HDE1	1.88	$253.84	0.91	$92.70
F	1.52	$117.74	1.51	$108.87	2.82	$81.58	HBC2	2.12	$286.24	0.68	$69.27
G	1.58	$122.39	1.55	$111.76	1.93	$55.83	HBC1	1.76	$237.64	-	-
H	1.10	$85.21	1.09	$78.59	2.70	$78.11	LDE2	1.97	$265.99	-	-
I	1.07	$82.88	1.12	$80.75	3.34	$96.63	LDE1	1.64	$221.43	-	-
J	1.34	$103.80	1.37	$98.78	2.83	$81.87	LBC2	1.63	$220.08	-	-
K	1.44	$111.54	1.46	$105.27	3.50	$101.26	LBC1	1.35	$182.28	-	-
L	1.03	$79.78	1.05	$75.71	3.98	$115.14	CDE2	1.77	$238.99	-	-
M	1.20	$92.95	1.23	$88.68	-	-	CDE1	1.53	$206.58	-	-
N	1.40	$108.44	1.42	$102.38	-	-	CBC2	1.47	$198.48	-	-
O	1.47	$113.87	1.47	$105.99	-	-	CA2	1.03	$139.07	-	-
P	1.02	$79.01	1.03	$74.26	-	-	CBC1	1.27	$171.48	-	-
Q	-	-	-	-	-	-	CA1	0.89	$120.17	-	-
R	-	-	-	-	-	-	BAB2	0.98	$132.32	-	-

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
S	-	-	-	-	-	-	BAB1	0.94	$126.92	-	-
T	-	-	-	-	-	-	PDE2	1.48	$199.83	-	-
U	-	-	-	-	-	-	PDE1	1.39	$187.68	-	-
V	-	-	-	-	-	-	PBC2	1.15	$155.27	-	-
W	-	-	-	-	-	-	PA2	0.67	$90.46	-	-
X	-	-	-	-	-	-	PBC1	1.07	$144.47	-	-
Y	-	-	-	-	-	-	PA1	0.62	$83.71	-	-

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	$128.04	1.41	$114.35	0.64	$23.32	ES3	3.84	$495.36	3.06	$297.83
B	1.61	$142.16	1.54	$124.89	1.72	$62.68	ES2	2.90	$374.10	2.39	$232.62
C	1.78	$157.17	1.60	$129.76	2.52	$91.83	ES1	2.77	$357.33	1.74	$169.35
D	1.81	$159.82	1.45	$117.60	1.38	$50.29	HDE2	2.27	$292.83	1.26	$122.64
E	1.34	$118.32	1.33	$107.86	2.21	$80.53	HDE1	1.88	$242.52	0.91	$88.57
F	1.52	$134.22	1.51	$122.46	2.82	$102.76	HBC2	2.12	$273.48	0.68	$66.18
G	1.58	$139.51	1.55	$125.71	1.93	$70.33	HBC1	1.76	$227.04	-	-
H	1.10	$97.13	1.09	$88.40	2.70	$98.39	LDE2	1.97	$254.13	-	-
I	1.07	$94.48	1.12	$90.83	3.34	$121.71	LDE1	1.64	$211.56	-	-
J	1.34	$118.32	1.37	$111.11	2.83	$103.13	LBC2	1.63	$210.27	-	-
K	1.44	$127.15	1.46	$118.41	3.50	$127.54	LBC1	1.35	$174.15	-	-
L	1.03	$90.95	1.05	$85.16	3.98	$145.03	CDE2	1.77	$228.33	-	-
M	1.20	$105.96	1.23	$99.75	-	-	CDE1	1.53	$197.37	-	-
N	1.40	$123.62	1.42	$115.16	-	-	CBC2	1.47	$189.63	-	-
O	1.47	$129.80	1.47	$119.22	-	-	CA2	1.03	$132.87	-	-
P	1.02	$90.07	1.03	$83.53	-	-	CBC1	1.27	$163.83	-	-
Q	-	-	-	-	-	-	CA1	0.89	$114.81	-	-
R	-	-	-	-	-	-	BAB2	0.98	$126.42	-	-
S	-	-	-	-	-	-	BAB1	0.94	$121.26	-	-
T	-	-	-	-	-	-	PDE2	1.48	$190.92	-	-
U	-	-	-	-	-	-	PDE1	1.39	$179.31	-	-
V	-	-	-	-	-	-	PBC2	1.15	$148.35	-	-
W	-	-	-	-	-	-	PA2	0.67	$86.43	-	-
X	-	-	-	-	-	-	PBC1	1.07	$138.03	-	-
Y	-	-	-	-	-	-	PA1	0.62	$79.98	-	-