

[PROPOSED RULE - CMS-1843-P - RIN 0938-AV75](#)

Medicare SNF Prospective Payment System

Federal Fiscal Year 2027 Proposed Updates

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Link to Proposed Rule:

https://www.federalregister.gov/public-inspection/2026-06674/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities?utm_source=MarketingCloud&utm_medium=email&utm_campaign=CMS+Issues+FY27+SNF+PPS&utm_content=Federal+Register



1


FY 2027 Market Basket Update

Market Basket Percentage Increase

CMS proposes a **3.2%** FY 2027 SNF market basket increase based on IHS Global Inc.'s fourth-quarter 2025 forecast of the **2022-based SNF market basket**, rebased from the **2018-based market basket** in FY 2025.

After applying the **0.8 percentage point productivity adjustment**—the 10-year moving average of economy-wide private nonfarm business total factor productivity growth, as required by **ACA Section 3401(a)**—the resulting proposed FY 2027 SNF market basket update is **2.4%**.

This **2.4%** update is applied to the unadjusted Federal per diem rates for all **six PDPM components**.



2

FY 2027 Unadjusted Federal Per Diem Rates

Urban Rates (Table 3)

Urban rates apply to SNFs located in Core-Based Statistical Areas (CBSAs) as defined by OMB Bulletin 23-01.

Component	PT	OT	SLP	Nursing	NTA	Non-Case Mix
Per Diem	\$77.45	\$72.09	\$28.92	\$134.99	\$101.85	\$120.89

Rural Rates (Table 4)

Rural rates apply to SNFs not located in a CBSA.

Component	PT	OT	SLP	Nursing	NTA	Non-Case Mix
Per Diem	\$88.29	\$81.09	\$36.44	\$128.98	\$97.31	\$123.13



3

HIPPS Code NHNC1: Wage Index Adjustment & Total Payment

Table 9: Wage Index Adjustment (CBSA 23224, Wage Index 0.9346)

HIPPS	Case-Mix Adj. Per Diem	Labor Portion	WI Adj. Rate	Total (Labor + Non-Labor)
NHNC1	\$1,139.87	\$820.71	\$767.04	\$1,086.20

The labor portion (\$820.71) equals the case-mix adjusted per diem (\$1,139.87) × 72.0% labor-related share. The wage-index adjusted labor portion (\$767.04) equals \$820.71 × 0.9346 (CBSA 23224 wage index). The non-labor portion (\$319.16) equals \$1,139.87 × 28.0%. Total wage-adjusted per diem = \$767.04 + \$319.16 = \$1,086.20.



4

PDPM ICD-10 Mappings: FY 2027 Updates

FY 2027 ICD-10 Updates

No substantive changes to PDPM ICD-10 code mappings were identified for FY 2027. CMS reviews ICD-10 mappings annually to account for new codes added by the **National Center for Health Statistics (NCHS)**.

5

Observed PDPM Case-Mix Creep

Observed Case-Mix Creep

CMS has observed significant Case-Mix Index (CMI) increases *unlikely to reflect true patient acuity changes*. Specific MDS item trends from FY 2019 to FY 2023 include:

- Malnutrition reporting (I5600): rose from 5% to 47% of stays
- Swallowing disorder (K0100): from 4% to 21%
- Depression: from 4% to 19%
- Cognitive impairment: from 14% to 28%

Meanwhile, median per-diem therapy costs declined — PT fell from \$67 to \$51 and OT from \$58 to \$45 — suggesting *therapy intensity is not driving the CMI increase*. CMS estimates the aggregate CMI increase represents approximately \$4–5 billion in additional annual payments above what would be expected based on true acuity changes.

6

Case-Mix Creep: Proposed Adjustment Factors

CMS developed this adjustment methodology in response to observed PDPM case-mix creep since FY 2019. Using FY 2019 as the baseline year, CMS's regression framework compares actual FY 2023 per-diem payments by component against what would be expected if patient acuity had remained at FY 2019 levels, while controlling for legitimate acuity changes. The resulting factors represent the estimated proportion of each component's payment increase **attributable to coding behavior changes rather than true patient need**.

Option A: Component-Level Adjustments

CMS's regression framework (FY 2019 baseline) yields targeted adjustments per component:

- PT: +3.3%
- OT: +4.1%
- SLP: -15.9% (largest reduction — swallowing disorder coding rose from 4% to 21%)
- NTA: -1.9%
- Nursing: -10.6%

Applied as multipliers to unadjusted per diem rates before case-mix adjustment. For example, the Nursing base rate would drop from \$134.99 to ~\$120.67. More targeted — only penalizes components with **evidence of coding inflation**.

Option B: System-Wide Factor (0.957)

A single uniform factor of 0.957 applied across all five case-mix components equally. **Reduces total per-stay payment by approximately 3.6% regardless of the patient's HIPPS code**. Simpler to administer, but less precise — reduces payments for all patients equally, including those whose coding accurately reflects true acuity.

Key Open Questions for Comment

1. Baseline year: Is FY 2019 the appropriate pre-PDPM baseline, or should a later year (e.g., FY 2020 or FY 2021) be used to account for legitimate learning curve effects?
2. Methodology: Does the regression adequately control for true acuity changes (e.g., post-COVID patient complexity)?
3. Component vs. system-wide: Should adjustments be targeted by component or applied uniformly?
4. Transition: Should any adjustment be phased in over multiple years to minimize disruption?
5. Monitoring: What ongoing surveillance mechanisms should CMS use to detect future case-mix creep?



No adjustment is being finalized in this proposed rule.

7

Proposal: Remove HCP COVID-19 Vaccine Measure (FY 2028)

Rationale for Removal

CMS proposes removal of the **HCP COVID-19 Vaccine** measure because: **"the measure does not align with current clinical guidelines or practice."** When the measure was adopted in the **FY 2022 SNF PPS final rule** and became effective for the **FY 2023 QRP**, the U.S. was averaging **over 5,000 COVID-19 deaths per week**.

By contrast, weekly COVID-19 deaths during the past 6 months (**August 2025–January 2026**) ranged from only **188 to 488**, representing a **greater than 90% reduction from peak mortality**. The **2025–2026 CDC guidance** now recommends **shared clinical decision-making** for COVID-19 vaccination of healthcare personnel, meaning there is no single default recommendation to vaccinate a defined population. This is fundamentally different from the **universal recommendation** guidance in place when the measure was finalized.

The measure is reported via **CDC NHSN** and requires SNFs to track and report the COVID-19 vaccination status of **all healthcare personnel working in the facility for at least one day during the reporting period**. CMS adopted it as a **NHSN-reported measure** in the **FY 2022 SNF PPS final rule (87 FR 47502)**.



8

Proposal: Remove Patient/Resident COVID-19 Vaccine Measure (FY 2028)

Effective Date & MDS Item

Beginning with residents discharged on or after October 1, 2026, SNFs would no longer be required to collect and submit this measure for QRP purposes. The related MDS data element, **00350 – COVID-19 Vaccination Up-to-Date**, would become **voluntary effective October 1, 2026**, allowing SNFs to continue collecting the data for internal quality improvement if desired.

The item would be **formally removed from the MDS 3.0 instrument on October 1, 2027**, following the standard MDS revision process.

Timeline summary: October 1, 2026 – measure reporting no longer required; 00350 becomes voluntary. **October 1, 2027** – 00350 formally removed from MDS 3.0. **FY 2028** – first payment year unaffected by this measure.



9

RFI: Advanced Care Planning Measure Concepts

CMS is requesting stakeholder feedback on the relevance and use of quality measure concepts for **advance care planning (ACP)** in the SNF QRP. This is a **Request for Information only**, with no measures proposed yet. ACP helps individuals understand their health, clarify values, and communicate treatment preferences, which is especially important in SNFs due to common cognitive and functional challenges.



Why It Matters in SNFs

In post-acute care, residents' needs change as their health evolves, requiring regular reassessment and clear communication. Skilled nursing facility (SNF) residents face higher risks of acute decline, making advance care planning (ACP) crucial to avoid unwanted hospitalizations and honor their preferences. While SNFs must inform residents about advance directives under OBRA '87, there is no standardized ACP quality measure in the SNF Quality Reporting Program.



10

ACP RFI: Shared Decision-Making & Measure Priorities



Shared Decision-Making

Advance care planning facilitates shared decision-making by documenting resident preferences and ensuring goal-concordant care throughout care transitions, consistent with the Patient Self Determination Act of 1990 (PSDA). The PSDA requires all Medicare and Medicaid-participating providers to inform patients of their right to execute advance directives (living wills, healthcare proxies, POLST forms). CMS is exploring whether ACP measure concepts should focus on: (1) the presence of an advance directive in the medical record, (2) documentation of ACP conversations in the MDS, (3) goal-concordant care outcomes, or (4) staff training and competency in ACP facilitation.



Measure Priorities

CMS will prioritize evidence-based outcome measures that promote person-centered care practices and are feasible to collect via existing MDS infrastructure. Public comment is invited on: (1) which ACP measure concepts are most relevant and actionable in the SNF setting; (2) whether ACP measures should be process-based (e.g., documentation of ACP conversation) or outcome-based (e.g., goal-concordant care); (3) data sources and collection methods; (4) appropriate risk adjustment; and (5) potential disparities in ACP access across racial, ethnic, and socioeconomic groups. Comments should be submitted by June 1, 2026.



11

Proposal: Revised QRP Data Submission Deadlines (FY 2029)

Current vs. Proposed Deadline

Currently, SNFs have **4.5 months** (approximately **135 days**) after each quarterly data collection period to submit MDS assessment data to the **CMS QIES ASAP system**. This creates an approximately **9-month lag** between data collection and public reporting on **Care Compare**.

CMS proposes changing the deadline to the **15th day of the second month after the end of each calendar quarter**, beginning with the **FY 2029 SNF QRP** (applicable to **CY 2027 data**). This would reduce the submission window to approximately **45 days** per quarter and shorten the public reporting lag by up to **3 months**.

The same shortened deadline would also apply to **CDC NHSN data submissions**, including the **HCP Influenza Vaccine measure**. More timely submission would improve the currency of quality information available to consumers on **Care Compare** and support more responsive quality oversight.



12

QRP Submission Deadlines: Impact Analysis & Schedule

Impact Analysis

- 97.18% of all MDS assessments were already submitted within 45 days (based on 2024 data)
- Only 2.69% of assessments (~30,000 annually) would be impacted by the change
- 95% of SNFs already submit CDC NHSN data within 45 days
- No additional cost per SNF – only the timing changes, not the volume
- SNFs missing the new deadline face the existing 2 percentage point market basket reduction
- CMS proposes a one-year transition period (FY 2028) before the FY 2029 payment determination takes effect

Proposed CY 2027 Submission Schedule (FY 2029)

CY 2027 Quarter	Collection Period	Deadline (FY 2029)
Q1	Jan 1–Mar 31	May 17, 2027
Q2	Apr 1–Jun 30	Aug 16, 2027
Q3	Jul 1–Sep 30	Nov 15, 2027
Q4	Oct 1–Dec 31	Feb 15, 2028



13

All-Payer MDS: Why It Matters Now

Medicare Advantage now covers 54% of all Medicare beneficiaries – yet these residents are entirely excluded from SNF QRP quality calculations.

Why This Matters Now

In 2025, Medicare Advantage enrollment is projected at **54%** (about **33 million**), rising to **64%** by 2034. These enrollees are excluded from SNF QRP measures, creating a growing gap that may hide quality differences and affect program accuracy, especially in SNFs with many MA residents.



14

All-Payer MDS: The Proposal

CMS proposes requiring MDS data submission on all residents admitted for covered skilled care, regardless of payer source (Medicare FFS, Medicare Advantage, Medicaid, private pay, or other), beginning with residents admitted on or after October 1, 2029, for the FY 2031 SNF QRP payment determination.

CMS proposes using a modified version of the Medicare Benefits Policy Manual (Chapter 8, §30) definition of skilled services. Residents admitted or readmitted for covered skilled care (skilled nursing or skilled therapy services) would trigger MDS submission regardless of payer. Long-term residents "skilled in place" without a new admission or readmission would NOT be included.

The proposed definition requires SNFs to identify:

1. The primary payer at admission
2. Whether the resident is receiving covered skilled care
3. The start and end dates of the covered skilled stay

CMS acknowledges definitional complexity for MA residents — where "covered skilled care" is determined by the MA plan rather than Medicare FFS criteria — and invites comment on how to operationalize this definition.



15

All-Payer MDS: 3 New MDS Items Required

Three new MDS items would be added to the MDS 3.0 instrument, plus one existing item modified, to support all-payer data collection.



New Item 1: Primary Payer at Admission & Discharge

Captures payer source at both admission and discharge: Medicare FFS, Medicare Advantage, Medicaid, private pay, or other. Enables CMS to identify which residents trigger QRP submission requirements.



New Item 2: Start & End Dates of Covered Skilled Stay

Documents the precise start and end dates of the covered skilled care episode that triggers QRP submission. Distinguishes the skilled stay from the overall length of stay.



New Item 3: Type of Assessment Indicator

Identifies non-Medicare FFS discharge assessments in the QIES ASAP system, distinguishing them from standard Medicare FFS assessments for accurate QRP measure attribution.



16

All-Payer MDS: Burden & Alignment with Other Programs

Estimated Burden (FY 2031)

CMS estimates **1,133,649 additional MDS assessments** annually across **14,868 SNFs**, based on **FY 2023 claims data** for non-Medicare FFS skilled care admissions. The total burden increase is estimated at **+1,001,719 hours** and **+\$88 million annually** for all SNFs, or approximately **+67.38 hours** and **+\$5,921.86 per SNF per year**.

The burden estimate assumes **0.883 hours per assessment** and **\$77.55 per assessment**, based on a loaded wage rate of **\$87.83/hour** for MDS coordinators/registered nurses. CMS further estimates that the **net new burden above existing OBRA assessment requirements** is approximately **0.25 hours per assessment**, reflecting only the additional data elements needed for QRP submission.

Burden is partially offset because:

1. Many SNFs already collect MDS data on non-Medicare FFS residents for internal quality improvement or state Medicaid reporting purposes, but do not submit it to CMS.
2. OBRA '87 requirements already mandate comprehensive admission assessments for all residents with stays **≥14 days**, covering most non-FFS residents.
3. SNFs already trained in MDS completion for Medicare FFS residents would not require significant additional training.

Assessment volume and burden breakdown

Assessment Type	Volume	Hours per Assessment	Total Hours
5-Day Assessments	566,825	0.883	500,386
Discharge Assessments	566,824	0.883	500,334
Total	1,133,649	–	1,001,719



17

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18

All-Payer MDS: Alignment with Other CMS Programs

Alignment with Other CMS Programs

All-payer data submission is already required in several CMS quality reporting programs:

1. Inpatient Rehabilitation Facility (IRF) QRP – required since FY 2016.
2. Long-Term Care Hospital (LTCH) QRP – required since FY 2016.
3. Home Health (HH) QRP – required since CY 2017.
4. Hospice QRP – required since FY 2017.
5. Merit-Based Incentive Payment System (MIPS) – requires data on a specified percentage of patients regardless of payer.

Adopting this policy would align the SNF QRP with these programs and provide a more complete picture of SNF quality for consumers on Care Compare.




19

All-Payer MDS: Alignment with Other CMS Programs

Additional Benefits of All-Payer Data

<p>01</p> <hr/> <p>More accurate risk adjustment for quality measures by capturing the full resident population.</p>	<p>02</p> <hr/> <p>Identification of quality disparities across payer types.</p>
<p>03</p> <hr/> <p>Support for value-based care initiatives under Medicare Advantage.</p>	<p>04</p> <hr/> <p>Alignment with the CMS National Quality Strategy's goal of advancing health equity.</p>

CMS invites comment on whether the FY 2031 implementation timeline is feasible and whether additional transition support, such as technical assistance or phased implementation, would be beneficial.



20

SNF VALUE-BASED PURCHASING PROGRAM

SNF VBP Program: FY 2027 Updates

The SNF VBP Program, authorized by Section 1888(h) of the Social Security Act and amended by PAMA, reduces each SNF's Federal per diem rate by 2% in FY 2027. Sixty percent of withheld funds are redistributed as incentives, while 40% go to the Medicare Trust Fund. About \$203.41 million will be withheld, with \$122 million paid out based on performance across 8 measures.

#	Measure	Data Source
1	SNF HAI – Healthcare-Associated Infections	Claims-based
2	Total Nurse Staffing (HPRD)	Payroll-Based Journal (PBJ)
3	Nursing Staff Turnover	Payroll-Based Journal (PBJ)
4	DTC PAC SNF – Discharge to Community	Claims-based
5	Falls with Major Injury (Long-Stay)	MDS-based
6	DC Function – Discharge Function Score	MDS Section GG
7	Long Stay Hospitalization	Claims-based
8	SNF WS PPR – Within Stay Potentially Preventable Readmissions	Claims-based



21

SNF VALUE-BASED PURCHASING PROGRAM

SNF VBP: Snapshot Date Update & Technical Corrections

Snapshot Date Update

To align with the proposed QRP submission deadline change – from 4.5 months to 45 days – CMS proposes updating the "snapshot date" (the date on which CMS pulls MDS data for VBP measure calculations) for the DC Function and Falls with Major Injury (Long-Stay) MDS-based measures. The new snapshot date would be the 15th day of the second month after the last day of the applicable performance period, beginning with FY 2027 data. This ensures VBP measure calculations use the most complete and timely MDS data available. The change is proposed under 42 CFR 413.338 and would apply to both the performance period and baseline period data pulls for affected measures.



22

SNF VBP Estimated Performance Standards: FY 2029 & FY 2030

Section 1888(h)(3)(C) of the Social Security Act requires CMS to announce estimated performance standards for the SNF VBP Program no later than 60 days before the start of the applicable performance period. These estimated standards are published in the proposed rule; final standards will be published in the FY 2027 SNF PPS final rule. Performance standards are set at the 25th percentile (achievement threshold) and 75th percentile (benchmark) of SNF performance during the baseline period, using the most recent available data. SNFs that meet or exceed the benchmark receive the maximum achievement score of 10; SNFs at or above the achievement threshold receive a score of 1–9 based on their position between the threshold and benchmark.

Estimated FY 2029 Standards (Table 16)

Measure	Achievement Threshold	Benchmark
SNF HAI	0.92183	0.94491
Total Nurse Staffing	3.29119	5.87448
Nursing Staff Turnover	0.42696	0.76652
Falls w/ Major Injury	0.95455	0.99951
Long Stay Hospitalization	0.99768	0.99963
DC Function	0.41935	0.80879

Performance Period: FY 2029 (October 1, 2028 – September 30, 2029).

Baseline Period: FY 2025 (October 1, 2024 – September 30, 2025).

The **Total Nurse Staffing** benchmark of **5.87448 HPRD** reflects the 75th percentile of SNF staffing levels in the baseline period. The **SNF HAI** benchmark of **0.94491** represents the 75th percentile of SNFs with the lowest infection rates (higher = better for this measure). The **DC Function** benchmark of **0.80879** reflects the 75th percentile of SNFs achieving the highest functional improvement scores.



23

SNF VBP Estimated Performance Standards: FY 2030

Estimated FY 2030 Standards (Table 17)

Measure	Achievement Threshold	Benchmark
DTC PAC SNF	0.43478	0.68049
SNF WS PPR	0.86219	0.92400

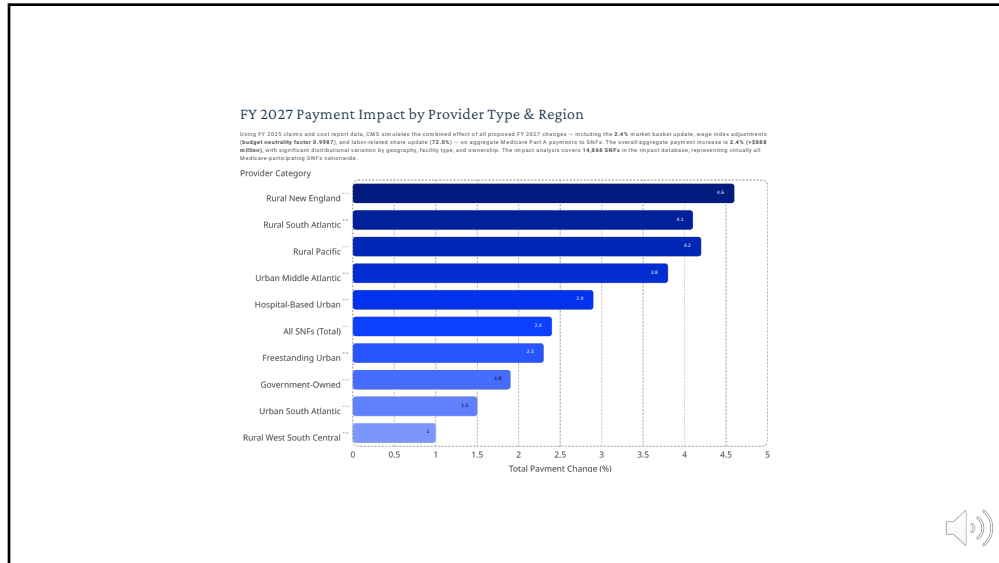
Performance Period: FY 2030 (October 1, 2029 – September 30, 2030). Baseline Period: FY 2026 (October 1, 2025 – September 30, 2026).

The DTC PAC SNF achievement threshold of 0.43478 means SNFs must discharge at least 43.5% of residents to the community to earn any achievement points. The SNF WS PPR benchmark of 0.92400 represents the 75th percentile of SNFs with the lowest potentially preventable readmission rates.

Estimated performance standards for the remaining FY 2030 measures (SNFRM, SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, Falls with Major Injury, DC Function, Long Stay Hospitalization) will be provided in the FY 2028 SNF PPS proposed rule, consistent with the 60-day advance notice requirement.



24



25

FY 2027 Payment Impact: Key Distributional Findings

Key Distributional Findings

- Rural providers overall: +2.7% (vs. +2.4% urban), driven by favorable wage index updates in rural CBSAs under OMB Bulletin 23-01 delineations.
- Rural New England: +4.6% – highest regional increase, reflecting significant wage index gains.
- Rural South Atlantic: +4.1%; Rural Pacific: +4.2% – also above-average rural increases.
- Middle Atlantic urban providers: +3.8% – highest urban regional increase.
- South Atlantic urban, East North Central urban, East South Central urban, West South Central urban: approximately +1.5–1.6% – lowest urban increases.
- Government-owned SNFs (959 facilities): +1.9% – smallest overall increase, reflecting lower wage index areas.
- For-profit SNFs (10,819 facilities): +2.4%; non-profit SNFs (3,090 facilities): +2.3%.
- Hospital-based SNFs: +2.9% (urban); rural hospital-based: +3.1%.
- Freestanding urban SNFs: +2.3%; freestanding rural SNFs: +2.8%.

Total facilities in impact database: 14,868 SNFs (10,819 for-profit, 3,090 non-profit, 959 government-owned). Values reflect the proposed FY 2027 market basket update of 2.4% plus or minus wage index adjustments by CBSA. Facilities in high-wage-index CBSAs benefit more from the labor-related share increase to 72.0%; facilities in low-wage-index areas see smaller increases. CMS notes that individual facility impacts may differ from regional averages based on their specific CBSA wage index and patient case-mix.

26

Key Takeaways & Comment Invitation

01

FY 2027 Payment Update: +2.4%

SNF Part A payments will increase by **\$888 million** (3.2% market basket increase minus 0.8% productivity adjustment) with a **0.9987** budget neutrality factor. Labor-related share rises to **72.0%**. Effective October 1, 2026.

02

SNF QRP: Two COVID-19 Measures Removed (FY 2028)

The HCP and Patient/Resident COVID-19 Vaccine measures are proposed for removal under CMS due to updated CDC guidance. Weekly COVID-19 deaths have dropped significantly, leading to an estimated burden reduction of 178,416 hours and \$8.4 million annually across 14,868 SNFs. MDS item O0350 will be voluntary from October 1, 2026, and removed by October 1, 2027.

03

Faster Data Submission Deadlines (FY 2029)

The MDS and NHSN submission deadline will shift from 135 days to about 45 days after each quarter, reducing public reporting delays by up to 3 months. In 2024, over 95% of data is already submitted within 45 days, so only 2.69% of assessments are impacted. This change applies to 2027 data for the FY 2029 QRP payment, with no extra cost for SNFs.



27

Key Takeaways & Comment Invitation (cont.)

01

All-Payer MDS Submission Required (FY 2031)

SNFs would be required to submit MDS data on all residents admitted for covered skilled care, regardless of payer (Medicare FFS, Medicare Advantage, Medicaid, private pay), beginning with residents admitted October 1, 2029 for the FY 2031 QRP. CMS estimates 1,133,649 additional MDS assessments annually and a total cost of \$88 million per year (\$5,921.86 per SNF). Medicare Advantage enrollment represented 54% of Medicare beneficiaries in 2025 and is projected to reach 64% by 2034. The proposal aligns SNF QRP with IRF, LTCH, HH, and Hospice QRPs and would add three new MDS items.

02

Case-Mix Creep RFI

CMS seeks comment on a regression-based methodology to address PDPM case-mix creep observed since FY 2019: malnutrition reporting rose from 5% to 47%, and swallowing disorders from 4% to 21%. The proposed system-wide adjustment factor is 0.957 (a 4.3% decrease), with component-level alternatives of PT +3.3%, OT +4.1%, SLP -15.9%, NTA -1.9%, and Nursing -10.6%. No adjustment is finalized in this rule.

Comment Deadline: June 1, 2026. Submit via: (1) [regulations.gov](https://www.regulations.gov) – search file code CMS-1843-P; (2) Mail: CMS, P.O. Box 8016, Baltimore, MD 21244-8016; (3) Overnight/courier: CMS, Mail Stop C4-26-05, 7500 Security Blvd., Baltimore, MD 21244-1850. Key contacts: PPS/PDPM issues – PDPMP@cms.hhs.gov; QRP issues – Heidi Magladry, (410) 786-6034; VBP issues – Christopher Palmer, (410) 786-8025. All comments become part of the public record and will be considered in the FY 2027 SNF PPS final rule, expected by August 1, 2026.



28

Questions & Discussion

Your Questions & Insights Are Welcome.

Thank you for your attention to the proposed FY 2027 SNF PPS rule. We now invite your questions, comments, and feedback on these crucial updates and proposals. judy@judywilhide.com

