

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OFFICE OF MANAGEMENT AND BUDGET
PAPERWORK REDUCTION ACT
CLEARANCE PACKAGE**

SUPPORTING STATEMENT-PART A

REVISION OF THE MINIMUM DATA SET (MDS) 3.0 (v1.20.1)
NURSING HOME AND SWING BED PROSPECTIVE PAYMENT SYSTEM (PPS)
FOR THE COLLECTION OF DATA
PERTAINING TO THE
PATIENT DRIVEN PAYMENT MODEL (PDPM) & THE SKILLED NURSING FACILITY
QUALITY REPORTING PROGRAM (QRP)

SUPPORTING STATEMENT-PART A
MDS 3.0
FOR THE COLLECTION OF DATA PERTAINING TO
THE PDPM AND SNF QRP

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Supporting Statement A
Minimum Data Set 3.0 Nursing Home and Swing Bed Prospective Payment System (PPS)
For the collection of data related to the Patient Driven Payment Model and the Skilled Nursing
Facility Quality Reporting Program (QRP)
CMS-10387, OMB 0938-1140

This package is a request for a revision to the currently approved Minimum Data Set (MDS) assessment instrument for the Skilled Nursing Facility (SNF). This package represents a request to implement the MDS 3.0 v1.20.1 beginning October 1, 2025 in order to meet the requirements of policies finalized in the Federal Fiscal Year (FY) 2025 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) final rule (CMS-1802-F, RIN 0938-AV30). Specifically, CMS finalized the collection of four new items as standardized patient assessment data elements and modified one item collected as a standardized patient assessment data element. The changes associated with the policies finalized in the FY 2025 SNF PPS final rule, are summarized here and in the document included with the package, titled *Draft MDS 3.0 Item Set Change Table v1.20.1.pdf*:

• NEW: These four items will be added to the MDS v1.20.1.			
R0310	R0320.A	R0320.B	R0330

• MODIFIED: Item A1250 is currently collected on the MDS v1.19.1 and will be replaced by a new item R0340 on the MDS v1.20.1
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• REMOVED: These 22 items will be removed from the MDS v1.20.1.			
O0400A (7 items)	O0400B (7 items)	O0400C (7 items)	O0400E (1 item)

A. Background

1. Background of the MDS in Nursing Homes (NH)

The MDS is a uniform instrument used in every Medicare/Medicaid certified nursing home in the United States to assess resident condition. It was developed in response to the Landmark Institute of Medicine (IOM) Report on Nursing Home Quality in 1987 where the MDS was seen as a critical component in efforts to improve the quality of care in nursing homes. From its inception, the MDS was intended to serve several purposes:

- (1) Collect data to inform care plans
- (2) To generate quality indicators to evaluate nursing homes and guide improvement interventions
- (3) To serve as a data source for nursing home payment systems.

Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA), but it has been determined that requirements for SNF staff performing, encoding and

transmitting patient assessment data necessary to administer the payment rate methodology described in 413.337, are subject to the PRA.

The SNF QRP was established in CMS-1622-F (August 4, 2015; 80 FR 46390) and began collecting data from SNFs in FY 2016 using the MDS.

Regarding the SNF Quality Reporting Program (SNF QRP), **Table 1** lists the quality measures collected via the MDS 1.19.1, currently in use.

Table 1: Quality Measures Collected via the MDS 1.19.1

Quality Measures Adopted for the FY 2026 SNF QRP Short Name	Measure Name
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) (NQF #0674).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC)
TOH-Patient	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC)
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percentage of Patients/Residents Who Are Up to Date

Both the Patient Driven Payment Model (PDPM) in the SNF PPS and the SNF QRP collect data through the MDS 3.0. The PDPM was described and adopted for SNFs and Swing Beds in CMS-1696-F (August 8, 2018; 83 FR 39162).

2. Background of this PRA Package

This package is a request for a revision to the current MDS assessment instrument for the SNF and is associated with the August 6, 2024 (89 FR 64048) “Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025” final rule (CMS-1802-F, RIN 0938-AV30). As outlined in the FY 2019 SNF PPS final rule (83 FR 39165 through 39265), several MDS items are not needed in case-mix adjusting the per diem payment for PDPM, but they were not accounted for in the FY 2019 SNF PPS final rule. Therefore, these items were removed from the 5-day Medicare-required assessment beginning October 1, 2025. The final rule also finalized the collection of four new items as standardized patient assessment data elements and the modification of one item collected as a standardized patient assessment data element. As a result of these changes, the total annual hour burden and cost across SNFs has decreased. These changes are reflected in Table 6 in Section 15.

B. Justification

1. Need and Legal Basis

Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA), but it has been determined that requirements for SNF staff performing, encoding and transmitting patient assessment data for the PPS 5-day (NP item set), the Swing Bed PPS (SP item set), the Interim Payment Assessment (IPA item set), the Swing Bed discharge (SD), and the PPS discharge (NPE item set) assessments, necessary to administer the payment rate methodology described in 413.337, are subject to the PRA.

Section 1888(e)(6)(B)(i)(II) of the Act requires that each SNF submit, for FYs beginning on or after the specified application date (as defined in section 1899B(a)(2)(E) of the Act), data on quality measures specified under section 1899B(c)(1) of the Act and data on resource use and other measures specified under section 1899B(d)(1) of the Act in a manner and within the timeframes specified by the Secretary. In addition, section 1888(e)(6)(B)(i)(III) of the Act requires, for FYs beginning on or after October 1, 2018, that each SNF submit standardized patient assessment data required under section 1899B(b)(1) of the Act in a manner and within the timeframes specified by the Secretary. Section 1888(e)(6)(A)(i) of the Act requires that, for FYs beginning with FY 2018, if a SNF does not submit data, as applicable, on quality and resource use and other measures in accordance with section 1888(e)(6)(B)(i)(II) of the Act and standardized patient assessment in accordance with section 1888(e)(6)(B)(i)(III) of the Act for such FY, the Secretary reduce the market basket percentage described in section 1888(e)(5)(B)(ii) of the Act by 2 percentage points.

Section 2(a) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act amended the Social Security Act (the Act) by adding section 1899B to the Act, which requires, among other things, SNFs to report standardized patient assessment data, data on quality measures, and data on resource use and other measures. Under section 1899B(m) of the Act, modifications to the SNF assessment instrument, here the MDS, required to achieve standardization of patient assessment data are exempt from PRA requirements. Standardization has been met upon our adoption of the proposed data elements and standardized patient assessment data in CMS-1718-F. For FY 2020 and thereafter, the exemption of the SNF QRP from the PRA is no longer applicable such that the SNF QRP requirements and burden will be submitted to OMB for review and approval. The active ICR serves as the basis for which we now address the previously exempt requirements and burden.

2. Information Users

CMS uses the MDS 3.0 PPS Item Sets (NP, NPE, SP, SD, IPA) to collect the data used to reimburse skilled nursing facilities for SNF-level care furnished to Medicare beneficiaries and to collect information for quality measures and standardized patient assessment data under the SNF QRP.

In addition, the public/consumer is a data user, as CMS is required to make SNF QRP data available to the public after ensuring that a SNF has the opportunity to review its data prior to public display. Measure data is currently displayed on the Nursing Homes Including Rehab Services Compare website at <https://www.medicare.gov/care-compare/?providerType=NursingHome>. The public display of quality measure data by CMS imposes no additional burden on SNFs.

a) Consideration of Burden of Information Collection Requests

CMS continually looks for opportunities to minimize burden associated with collection of the MDS for information users through strategies that (1) simplify collection and submission requirements, (2) improve MDS comprehension, (3) enhance communication, navigation, and outreach, (4) minimize learning costs, and (5) provide flexible time frames for data submission.

First, interviews are conducted with information users before new items are introduced. The interviews provide valuable evidence in order to ensure the item(s) are precise and result in meaningful information.

Second, improving MDS comprehension is a priority. A number of strategies are used, including standardizing the collection instructions across all SNFs, ensuring that all instructions and notices are written in plain language, and by providing step-by-step examples for completing the MDS. Human-centered design best practices are used, such as prioritizing key communication in headings, text boxes, and bold text. Close attention is paid to the amount of information required in the forms so that only the necessary data is collected on the MDS.

Third, CMS looks for opportunities to improve communication with users and conducts outreach. CMS provides a dedicated help desk to support users and respond to questions about the data collection. Additionally, a dedicated SNF QRP webpage houses multiple modes of tools, such as instructional videos, case studies, user manuals, and frequently asked questions which support understanding of the MDS and can be used by current and new users of the MDS. CMS utilizes a listserv to facilitate outreach to users, such as communicating timely and important new material(s), as well as reminders and alerts related to the MDS completion. Finally, CMS provides a free internet-based system through which users can access on-demand reports for feedback on the collection of the MDS associated with their facility.

Fourth, CMS is aware of the learning costs that SNFs may incur when new data collection is required. CMS provides multiple free training resources and opportunities for SNFs to use, reducing the burden to SNFs in creating their own training resources. These training resources include live training, online learning modules, tip sheets, and/or recorded webinars and videos. Having the materials online and on-demand gives SNFs the flexibility to use the materials in a group setting or on an individual basis at times that work for them.

Fifth, CMS allows up to 4.5 months for SNFs to submit all data required in this information collection, providing ample time for data submission. CMS acknowledges that some small providers may experience difficulties complying with data collection requirements, and having additional time may reduce the stress and anxiety SNF providers may experience.

3. Improved Information Technology

CMS uses information technology to decrease the burden associated with data collection of the MDS. This is accomplished through strategies that (1) streamline information and submission processes, (2) minimize costly documentation requirements, and (3) utilize information technology for improving communication.

First, CMS creates data collection specifications for SNF electronic health record (EHR) software with ‘skip’ patterns to ensure the MDS is limited to the minimum data required to meet quality reporting requirements and to calculate SNF payment. These specifications are available free of charge to all SNFs and their technology partners. Further, these minimum requirements are standardized for all users of the MDS assessment forms. CMS also provides flexibility to SNFs by giving them the option of recording the required data on a printed form and later transferring the data to electronic format or they can choose to directly enter the required data electronically to the CMS designated submission system, which is currently used by SNFs, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs).

Second, CMS has minimized costly documentation requirements by allowing SNFs to electronically self-attest to the accuracy of the data in the MDS prior to transmitting the MDS, eliminating the need for supportive documentation to be submitted with the MDS. CMS has also developed customized software that allows SNFs to encode, store and transmit the MDS data. The software is available free of charge on the CMS Website at <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqimds30technicalinformation>. Additionally, the software delivers real-time warnings to the SNF when the data is incomplete. SNFs receive warnings when the data is accepted by the system but may be incomplete for purposes of quality reporting submission. SNFs receive fatal warnings when the data collection form is not accepted by the system for any reason.

Third, we provide customer support for software and transmission problems encountered by the providers. SNFs have the ability to self-select their preferred method of communication. For example, we have dedicated help desks to respond to questions about issues SNFs may encounter with the software. We also offer SNFs the ability to sign up for listservs that send out timely and important new information, reminders, and alerts via electronic mail related to the software. CMS has also established a website to assist providers with questions regarding the MDS, at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>. This website publishes new information related to the MDS, houses archived versions of the tool, and is available at all times to SNFs.

4. Duplication of Efforts

The data required for reimbursement and monitoring the effects of the SNF PDPM on patient care and outcomes are not available from any other source.

This data collection for the QRP does not duplicate any other effort and the standardized data cannot be obtained from any other source. There are no other data sets that will provide comparable information on residents admitted to SNFs.

5. Small Businesses

As part of our PRA analysis for a revision to our existing approval, we considered whether the change impacts a significant number of small entities. In this filing we utilized the instructions that pertain to the Paperwork Reduction Act Submission Worksheet, Part II to determine the number of small entities. Specifically, a small entity can be defined as a small organization that is any not-for-profit enterprise that is independently owned and operated and is not dominant in its field. Data indicate that in 2023, 20% of the total SNF number were non-profit. This equates to 3,095 non-profit SNFs.

Provider participation in the submission of quality data is mandated by Section 3004 of the Affordable Care Act and Section 1899B(c)(2)(A) of the IMPACT Act. Small business providers viewing the data collection as a burden can elect not to participate. However, if a SNF does not submit the required quality data, this provider shall be subject to a 2% reduction in their payment update for the standard Federal rate during that rate year.

6. Less Frequent Collection

Under the PDPM payment system we need to collect this information at the required frequency, that is, at the start of a resident's Part A SNF stay to classify the resident into a payment category, and upon discharge from a SNF stay for monitoring purposes. The IPA is an optional assessment for the PDPM and is not used for the SNF QRP.

For the SNF QRP, the data collection time points and data collection frequency are consistent with the PDPM payment system. Data is collected for the SNF QRP both at the start of a resident's Part A SNF stay and upon discharge from a resident's Part A SNF stay in order to calculate the quality measures adopted under the SNF QRP and to obtain standardized patient assessment data.

7. Special Circumstances

There are no special circumstances that would require the PPS 5-Day and PPS discharge assessments to be conducted more than once during a resident's stay.

SPD 15 Implementation Update

We support implementing the latest SPD-15 directive.

For the FY/CY 2026 Rulemaking seasons, we intend to discuss our plans to implement Figure 3, the minimum categories with the expectation to implement in our 5 PAC Programs beginning in 2027. The implementation of this standard sooner would be a significant burden for the following reasons—

- Existing standardized patient assessment instruments (PAIs) collect information on patients' race and/or ethnicity using an earlier standard. By statute, all PAIs must propose the data items, including race/ethnicity via notice and comment rulemaking. This means that to add the race/ethnicity from SPD 15, we would need to propose the time, place, and manner of adding the SPD 15 race/ethnicity in each of its rules.

- While we have begun preliminary conversations with our Information Systems Group (ISG) colleagues for implementation following rulemaking, adoption of this standard (like any new work) requires adequate time for vendors, States, other CMS components, and federal agencies to implement updates to their respective systems, databases, finder files, etc.
- We need to allow for the 12-month period allotted prior to implementation of any updates and related trainings to the assessment tools and technical data specifications, our various data bases, and impacted reports. We plan to incorporate the Race and Ethnicity Question with Minimum Categories only (no examples or write-ins) (as shown in Figure 3 of the Federal Register posting).
- With the very long list of race/ethnicity options, it may be more difficult to administer the longer version by PAC staff, especially to an older and sicker Medicare-aged population. This version of the question aligns with current versions used on the PAC patient assessment instruments. The minimum categories reduce provider burden and patient/resident/family confusion since the staff must read the questions to the patient/resident for their response. We also need to consider the translations for patients who need staff to ask the questions in a language other than English. Based on testing from other write-in considerations, we have proven that we cannot use the data. Aside from spelling issues and how many write-ins should be allowed, we seek inter-operability, and write-ins do not allow for it. Further, the current data lacks sufficient N to include sub-groups at the facility level. Therefore, we roll-up the data to the Minimum Categories. Currently, we can only show white and non-white to represent some PAC data. The increased burden to staff would be significant to implement other than the Minimum Categories and not improve the data quality. Additionally, to make statements about the data will require roll-up to the Minimum Categories since we do not use the examples or write-ins due to the small Ns. We could include the examples in our manuals as guidance, but due to the high burden and confusion would use the Minimum Categories in the assessment instruments.

8. Federal Register/Outside Consultation

The FY 2025 SNF PPS Notice of Proposed Rulemaking (89 FR 23424) published on April 3, 2024. CMS received nine comments related to the proposed burden estimate in the proposed rule.

Several of these commenters noted that data collection is financially burdensome and increases burden on already overextended staff. One commenter urged CMS to reevaluate the utility of collecting this information, particularly compared to the burden of data collection. Three commenters recognized the importance of collecting information on residents' food access through a streamlined data collection process but recommended that CMS combine the two proposed Food assessment items into a singular comprehensive assessment item to enhance efficiency and reduce respondent burden, while still capturing the nuanced aspects of food insecurity crucial for care planning and recourse allocation. CMS responded to those comments

in the FY 2025 SNF PPS Final Rule (89 FR 64048) that was published on August 6, 2024. The removal of 22 items in Section O of the MDS, the collection of four new items as standardized patient assessment data elements, and the modification of one item collected as a standardized patient assessment data element were finalized. As a result, SNFs will collect MDS data using the MDS 1.20.1 beginning October 1, 2025. This final rule can be found here:

<https://www.federalregister.gov/documents/2024/08/06/2024-16907/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.

CMS informed the provider community on July 31, 2024. A reference to the announcement can be found on the SNF QRP webpage found here: <https://www.cms.gov/medicare/quality/snf-quality-reporting-program/spotlights-announcements>.

The 60-day comment period Federal Register notice published XXXXXXXXXXXX.

The 30-day comment period Federal Register notice published XXXXXXXX.

9. Payment/Gifts to Respondent

There will be no gifts and no payment to respondents for the use of the MDS.

10. Confidentiality

The system of records (SOR) establishes privacy stringent requirements. The MDS SOR was published in the Federal Register on May 22, 1998 (63 FR 28396). A SOR modification notice was subsequently published in the Federal Register on July 16, 1998 (63 FR 38414), Aug 18, 2000 (65 FR 50552), February 13, 2002 (67 FR 6714), and March 19, 2007 (72 FR 12801).

CMS has also provided, as part of the current Manual, a section that addresses in writing statements of confidentiality consistent with the Privacy Act of 1974. To address concerns about confidentiality of resident data, we provide that a facility and a State may not release resident-identifiable information to the public and may not release the information to an agent or contractor without certain safeguards (42 CFR 483.20(f)(5) and 483.315(j)). Data will be kept private to the extent allowed by law.

11. Sensitive Questions

There are no sensitive questions on the MDS 3.0 v1.20.1.

12. Collection of Information Requirements and Annual Burden Estimates

The active information collection request (approved August 21, 2023) sets out burden estimates for the item sets NP, NPE, and IPA, which are the item sets used for the PDPM. We continue to use the number of items (272) on the OMRA (NO/SO) item set as a proxy for all assessments, consistent with the active information collection request.

We have updated the MDS burden estimates on skilled nursing facilities. The assessment-level burden hours approved for the previous version MDS 3.0 v1.19.1 remain intact in the estimate.

However, the updated MDS burden estimates reflects updated information:

- We used FY 2023 data to calculate the frequency and number of assessments completed;
- We updated the salary estimate using the U.S. Bureau of Labor Statistics (BLS) from May 2022 to May 2023.
- We have accounted for the removal of the 22 assessment items not needed in case-mix adjusting the per diem payment for PDPM as finalized in the FY 2025 SNF PPS Final Rule (89 FR 64146 through 64148).
- We have accounted for the collection of the four new assessment items and one modified item as standardized patient assessment data elements for the SNF QRP as finalized in the FY 2025 SNF PPS Final Rule (89 FR 64144 through 64146).

As a result, the total burden has decreased. We provide additional details about the changes in Section 15 of this package.

Wage Estimates

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.¹ To account for other indirect costs and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 2.

Table 2. U.S. Bureau of Labor and Statistics' May 2023 National Occupational Employment and Wage Estimates.

Occupation title	Occupation code	Median Hourly Wage (\$/hr)	Overhead and Fringe Benefit (\$/hr)	Adjusted Hourly Wage (\$/hr)
Registered Nurse (RN)	29-1141	\$41.38	\$41.38	\$82.76
Licensed Vocational Nurse (LVN)	29-2061	\$28.72	\$28.72	\$57.44

Assumptions

According to the On-Line Survey and Certification System (OSCAR), there were approximately 15,477 skilled nursing facilities in FY 2023. Based on our SNF monitoring information, there were approximately 1,966,662 5-day scheduled PPS assessments and 1,224,154 discharge assessments completed and submitted by Part A SNFs in FY 2023. Based on FY 2023 data, an Interim Payment Assessment (IPA) was completed for approximately 4.4% of residents admitted for a Part A PPS stay have, resulting in 86,084 IPAs completed.

We estimate that the total number of 5-day scheduled PPS assessments, IPAs, and PPS discharge assessments that would be completed under the PDPM across all facilities is 3,276,900 (1,966,662 + 86,084 + 1,224,154, respectively).

Collection of Information Requirements and Associated Burden Estimates

¹ https://www.bls.gov/oes/current/oes_nat.htm.

Based on our understanding of the MDS 3.0 and after discussions with clinicians, we estimate that it will take 51 minutes (0.85 hours) to complete a single PPS Assessment.

MDS 3.0 PPS Burden Estimates for the SNF PDPM

There were 15,477 SNFs which sought reimbursement under the year to date projected SNF PPS during FY 2023. The total estimated time for MDS 3.0 PPS Assessment preparation and coding across 15,477 facilities is 2,785,365 hours per year (3,276,900 assessments x 0.85 hours) (See Table 3).

Table 3. MDS 3.0 PPS Burden Estimates for the SNF PDPM.

Number of SNFs seeking payment	Estimated total number of assessments completed under PDPM	Estimate of time to complete a single PPS Assessment (hours)	Total Annual Hour Burden Across Facilities per year
15,477	3,276,900	0.85	2,785,365

In the FY 2025 SNF PPS Final Rule (89 FR 89 FR 64146 through 64148), CMS finalized the removal of 22 assessment items from the 5-day Medicare-required assessment beginning October 1, 2025: O0400.A. Speech-Language Pathology and Audiology Services (7 items); O0400.B. Occupational Therapy (7 items); O0400.C. Physical Therapy (7 items); and O0400.E. Psychological Therapy (1 item). The net result of removing the collection of these items is a decrease of 6.6 minutes of clinical staff time at admission. We believe that these items are completed equally by a RN and LPN/LVN.

Estimate of the Burden: As displayed in Table 4, the net result of the removal of these items will decrease the burden of completing the 5-day Medicare-required assessment. Using data from fiscal year 2023, we estimated 1,966,662 admissions to 15,477 SNFs annually and 127 5-day PPS assessments per provider per year. This equates to a decrease of 216,333 hours in burden for all SNFs (1,966,662 5-day PPS assessments x 0.11 hour for the 22 items). We believe the SNF items affected by this removal are completed by Registered Nurses (RN) and Licensed Practical and Licensed Vocational Nurses (LPN/LVN). Therefore, we averaged the national median for these labor types and established a composite cost estimate of \$70.10. This composite estimate was calculated by weighting each salary based on the following breakdown regarding provider types most likely to collect this data: RN 50 percent and LVN 50 percent. For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.² To account for other indirect costs and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 2.

Table 4. Burden Hours and Cost Calculation for the SNF PDPM beginning October 1, 2025:

Number of SNFs in U.S. in 2023	15,477
Average number of MDS 5-day PPS item sets submitted per each SNF	127

² https://www.bls.gov/oes/current/oes_nat.htm.

Estimated number of MDS 5-day PPS item sets submitted for all SNFs	1,966,662
Hours to collect the 22 assessment items	0.11
Decrease in Hours for each SNF annually	-14
Decrease in Hours for all SNFs annually	-216,333
Previous Total Hours for all SNFs annually	2,861,351
New Total Hours for all SNFs annually	2,645,018
Previous Cost Burden for all SNFs per year	\$209,755,274.80
New Cost Burden for all SNFs annually	\$185,415,761.80

MDS 3.0 Burden Estimates for the SNF QRP

The burden associated with the SNF QRP is the time and effort required for complying with the SNF QRP. The estimated burden for completing the MDS was established in the FY 2012 SNF PPS Final Rule. Since the establishment of the MDS, CMS has calculated programmatic burden accounting for the time and cost it takes a SNF to encode the MDS, prepare the data for electronic submission, and transmit the data to CMS. Our estimates of time to complete new items is based on past SNF burden calculations, and our assumptions for staff type are based on the categories generally necessary to collect this data, and subsequently encode it.³ However, individual providers determine their own processes to collect the information and the staffing resources necessary to collect it. We acknowledge that some SNFs will incur a higher cost than was estimated, while some SNFs will incur a lower cost.

a) Assessing Burden of Information Collection

Before adding a new assessment item to the MDS, CMS considers several factors including the need for collection of the item(s) and the burden associated with complying with the SNF QRP. These considerations include a functional description of the item, evaluating the need for the collection, and providing a specific, objectively supported estimate of the burden we anticipate these new collections will impose on SNFs. We have outlined these considerations in the FY2025 SNF PPS final rule and in this section under assessment item proposals that we anticipate will add burden when completing the MDS v1.20.1.

In the FY 2025 SNF PPS final rule, we estimate an overall increase in the total burden incurred for the FY 2027 SNF QRP as a result of these proposals becoming final.

b) Collection of Four New Items as Standardized Patient Assessment Data Elements and Modification of One Item Collected as a Standardized Patient Assessment Data Element Beginning with the FY 2027 SNF QRP

In the FY 2025 SNF PPS Final Rule (89 FR 64100 to 64112), CMS finalized a requirement for SNFs to report the following four new items to be collected as standardized patient assessment data elements in the MDS under the Social Determinants of Health (SDOH) category under the SNF QRP: one item for Living Situation; two items for Food; and one item for Utilities. CMS also finalized the modification of one of the current items collected as standardized patient

³ FY 2012 Final Rule (76 FR 48486), FY 2014 Final Rule (78 FR 47936), FY 2015 Final Rule (79 FR 46390), FY 2018 Final Rule (82 FR 39162), FY 2019 Final Rule (83 FR 17620), FY 2020 Final Rule (84 FR 38728), FY 2024 Final Rule (88 FR 53200)

assessment data under the SDOH category. As a result, the estimated burden and cost for SNFs for complying with requirements of the FY 2027 SNF QRP will increase. Specifically, we believe there will be 0.02 hour increase in clinical staff time to report data per resident stay.

Functional Description of the items: The new items and modified item are collected at admission to the SNF. The Living Situation item asks “What is your living situation today?” The response options are: (0) I have a steady place to live; (1) I have a place to live today, but I am worried about losing it in the future; (2) I do not have a steady place to live; (7) Resident declines to respond; and (8) Resident unable to respond. The first Food item states, “Within the past 12 months, you worried that your food would run out before you got money to buy more.” The second Food item states, “Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.” We finalized the same response options for both items: (0) Often true; (1) Sometimes true; (2) Never True; (7) Resident declines to respond; and (8) Resident unable to respond. The Utilities item asks, “In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?” The response options are: (0) Yes; (1) No; (2) Already shut off; (7) Resident declines to respond; and (8) Resident unable to respond. The Transportation item asks, “In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?” The response options are: (0) Yes; (1) No; (7) Resident declines to respond; and (8) Resident unable to respond. A draft of what the new and modified items will look like can be found in the Downloads section of the SNF QRP Measures and Technical Information webpage and readers can view it at <https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information>. The draft MDS v1.20.1, which includes these items, will be made available in the Downloads section of the MDS 3.0 RAI Manual webpage and readers will be able to view it <https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual>.

Evaluation of the need for the items: Section 1899B(b)(1)(B)(vi) of the Act authorizes the Secretary to collect standardized patient assessment data elements with respect to other categories deemed necessary and appropriate. Accordingly, we finalized the creation of the SDOH category of standardized patient assessment data elements in the FY 2020 SNF PPS final rule (84 FR 38805 through 38817), and defined SDOH as the socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health.⁴ According to the World Health Organization, research shows that the SDOH can be more important than health care or lifestyle choices in influencing health, accounting for between 30-55% of health outcomes.⁵ This is a part of a growing body of research that highlights the importance of SDOH on health outcomes. Access to standardized data relating to SDOH on a national level permits us to conduct periodic analyses, and to assess their appropriateness as risk adjusters or in future quality measures. Our ability to perform these analyses and to make adjustments relies on existing data collection of SDOH items from PAC settings. The SDOH items we are finalizing

⁴ Office of the Assistant Secretary for Planning and Evaluation (ASPE). Second Report to Congress on Social Risk and Medicare’s Value-Based Purchasing Programs. June 28, 2020. Available at: <https://aspe.hhs.gov/reports/second-report-congress-social-risk-medicare-value-based-purchasing-programs>.

⁵ World Health Organization. Social determinants of health. Available at: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

as standardized patient assessment data elements under the SDOH category in this final rule were also identified in the 2016 NASEM report⁶ or the 2020 NASEM report⁷ as impacting care use, cost, and outcomes for Medicare beneficiaries. The items have the capacity to take into account treatment preferences and care goals of residents and their caregivers, to inform our understanding of patient complexity and SDOH that may affect care outcomes, and ensure that SNFs are in a position to impact through the provision of services and supports, such as connecting residents and their caregivers with identified needs with social support programs.

Estimate of the Burden: As displayed in Table 5, while the net result of these finalized new and modified SDOH items will increase the burden, the burden of the modified Transportation item will decrease slightly as we are finalizing that SNFs will be required to collect this item at admission only, rather than at admission and discharge as is currently required. Using data from fiscal year 2023, we estimated 1,766,806 admissions to and 754,287 planned discharges from 15,477 SNFs annually and 114 admission assessments and 49 planned discharges per SNF. This equates to an increase of 30,565 hours in burden for all SNFs [(1,766,806 5-day PPS assessments x 0.02 hour for the four new SDOH items) minus [(199,856 5-day PPS assessments x 0.005 hour for the modified Transportation item) plus (754,287 planned discharges x 0.005 hour)]. We believe the SNF items affected by the proposal to collect four new items and modify one item are completed by Registered Nurses (RN) and Licensed Practical and Licensed Vocational Nurses (LPN/LVN). Therefore, we averaged the national median for these labor types and established a composite cost estimate of \$70.10. This composite estimate was calculated by weighting each salary based on the following breakdown regarding provider types most likely to collect this data: RN 50 percent and LVN 50 percent. For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics’ (BLS) May 2023 National Occupational Employment and Wage Estimates.⁸ To account for other indirect costs and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 2.

Table 5. Burden Hours and Cost Calculation for SNF-MDS v1.20.1 beginning with the FY 2027 SNF QRP:

Number of SNFs in U.S. in 2023	15,477
Average number of MDS 5-day PPS item sets submitted per each SNF for the FY 2027 SNF QRP	114
Estimated number of MDS 5-day PPS item sets submitted for all SNFs for the FY 2027 SNF QRP	1,766,806
Hours to collect the four new assessment items adopted as standardized patient assessment data elements and the one modified item currently collected as a standardized patient assessment data element adopted in the FY 2025 SNF PPS final rule	0.02
Increase in Hours for each SNF annually for the FY 2027 SNF QRP	2
Increase in Hours for all SNFs annually	30,565

⁶ Social Determinants of Health. Healthy People 2020. <https://odphp.health.gov/healthypeople> (February 2019).

⁷ National Academies of Sciences, Engineering, and Medicine. 2020. Leading Health Indicators 2030: Advancing Health, Equity, and Well-Being. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25682>.

⁸ https://www.bls.gov/oes/current/oes_nat.htm.

Previous Total Hours for all SNFs annually	2,645,018
New Total Hours for all SNFs annually	2,675,583
Previous Cost Burden for all SNFs per year	\$185,415,761.80
New Cost Burden for all SNFs	\$187,558,368.30

Basic Requirements for all Claims. In evaluating the impact of billing changes in the UB-04 common claim form (approved by OMB under control number 0938-0997) our long-standing policy is to focus on changes in billing volume.

Information Collection/Reporting Instruments and Instruction Guidance Documents
The Information Collection/Reporting Instruments for the PDPM and SNF QRP effective 10/1/2025 are the MDS 3.0 forms/Item Sets: NP, NPE, IPA.

- NP PPS (NP) Version 1.20.1 effective 10/1/2025 (Revised, see the Change Table for details)
- NPE Part A PPS Discharge (NPE) Version 1.20.1 effective 10/1/2025 (Revised, see the Change Table for details)
- IPA Version 1.20.1 effective 10/1/2025 (Unchanged, see section 15 for details)
- LTC RAI User’s Manual Version 1.20.11 (Revised) to be posted at:
<https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual>

Additional SNF QRP Programmatic Burden

As requested by OMB, CMS acknowledges there is SNF QRP programmatic burden associated with other data collection methods, including the Centers for Disease Control’s (CDC) National Healthcare Safety Network (NHSN).

The FY 2022 SNF PPS final rule (86 FR 42424) requires that SNFs submit data on the COVID-19 Vaccination Coverage among HCP measure beginning with the FY 2023 SNF QRP. However, this collection of information request does not set out such burden since the burden for collecting and reporting vaccination data is waived from the requirements of the PRA under section 321 of the National Childhood Vaccine Injury Act (NCVIA) (Pub. L. 99-660). Section 321 can be found in a note at 42 U.S.C. 300aa-1.

The FY 2023 SNF PPS final rule (87 FR 47502) requires that SNFs submit data on the Influenza Vaccination Coverage among HCP measure beginning with the FY 2024 SNF QRP. However, this collection of information request does not set out such burden since the burden for collecting and reporting vaccination data is waived from the requirements of the PRA under section 321 of the National Childhood Vaccine Injury Act (NCVIA) (Pub. L. 99-660). Section 321 can be found in a note at 42 U.S.C. 300aa-1.

13. Capital Costs (Maintenance of Capital Costs)

Facilities are currently required to collect, compile, and transmit MDS data. Therefore, there are no capital costs. Any other cost can be considered a cost of doing business.

14. Cost to Federal Government

The Department of Health & Human Services (DHHS) will incur costs associated with the administration of the SNF quality reporting program including costs associated with the IT system used to process SNF submissions to CMS and analysis of the data received.

CMS has engaged the services of an in-house CMS contractor to create and manage an online reporting/IT platform for the MDS. This contractor works with the CMS Center for Clinical Standards and Quality, Division of Post-Acute and Chronic Care (DCPAC) in order to support the IT needs of multiple quality reporting programs. When SNF providers transmit the data contained within the MDS to CMS it is received by this contractor. Upon receipt of all data sets for each quarter the contractor performs some basic analysis which helps to determine each provider's compliance with the reporting requirements of the SNF QRP. The findings are communicated to the SNF QRP lead in a report. Contractor costs include the development, testing, and roll-out of updates to data submission systems.

DCPAC had also retained the services of a separate contractor for the purpose of performing a more in-depth analysis of the SNF quality data, as well as the calculation of the quality measures, and future public reporting of the SNF quality data. Said contractor will be responsible for obtaining the SNF quality reporting data from the in-house CMS contractor. They will perform statistical analysis on this data and prepare reports of their findings, which will be submitted to the SNF QRP lead.

DCPAC has retained the services of a third contractor to assist us with provider training and support services related to the SNF QRP.

In addition to the contractor costs, the total includes the cost of the following Federal employees:

- GS-13 (locality pay area of Washington-Baltimore-Northern Virginia) at 100% effort for 3 years, or \$353,886.
- GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33.33% effort for 3 years, or \$139,395.

The estimated cost to the federal government for the contractor is as follows:

CMS in-house contractor – Maintenance and support of IT platform that supports the MDS	\$750,000
Data analysis contractor	\$1,000,000
Provider training & helpdesk contractor	\$1,000,000
GS-13 Step 1 Federal Employee (100% X 3 years at \$117,962 annually)	\$353,886
GS-14 Step 1 Federal Employee (33.33% X 3 years at \$46,465 annually)	\$139,395
Total cost to Federal Government:	\$3,243,281

15. Program Changes

Since the MDS 3.0 v1.19.1 was approved, CMS has finalized the collection of four new assessment items as standardized patient assessment data elements and modified one item

currently collected as a standardized patient assessment data element for the SNF QRP. Additionally, we removed MDS items that are not needed for case-mix adjusting the SNF per diem payment for PDPM but were not accounted for in the FY 2019 SNF PPS final rule ([83 FR 39165](#) through [39265](#)). We also continue to monitor the number of SNFs and the number of beneficiaries seeking SNF services. After a decline in SNF admissions due to the COVID-19 public health emergency, the number of individuals admitted to SNFs for skilled services continues to increase as represented by the 7.8% increase in the total number of assessments reported in this ICR from the previous ICR.

Finally, we updated the salary estimate using the U.S. BLS from May 2022 to May 2023, and reflected such wage updates in burden estimates.

These updates resulted in the following changes to the current burden estimate:

- An increase of six SNFs, with the current number at 15,477.
- This ICR estimates 1,966,662 SNF PPS 5-day assessments, an increase of 218,850 assessments over the last approved package.
- This ICR estimates 1,224,154 SNF PPS Discharge assessments, a decrease of 413,787 assessments over the last approved package.
- This ICR estimates 86,084 SNF PPS IPA assessments, an increase of 2,654 assessments over the last approved package.
- This ICR updates U.S. BLS data from May 2022 to May 2023 (see Table 2) resulting in an adjusted hourly wage for Registered Nurses of \$82.76, an increase of \$4.66 and an adjusted hourly wage for Licensed Vocational Nurses of \$57.44, an increase of \$4.92.

As a result of these changes (see Table 6), the total annual hour burden across facilities has decreased by 185,768 hours (2,861,351 minus 2,675,583), and the annual cost burden across facilities has decreased by \$22,196,906.50 (\$209,755,274.80 minus \$187,558,368.30).

Table 6. Burden Hours and Cost Calculation for MDS v1.20.1:

Previous Total Hours for all SNFs annually	2,861,351
New Total Hours for all SNFs annually	2,675,583
Previous Cost Burden for all SNFs per year	\$209,755,274.80
New Cost Burden for all SNFs per year	\$187,558,368.30

We have also updated the data submission system to the iQIES for the SNF QRP. This was a replacement of the legacy QIES ASAP data submission system and imposes no additional requirements or burden on the part of SNFs.

16. Publication and Tabulation Dates

Not applicable.

17. Expiration Date

The PRA Disclosure statement can be found in the Downloads section on the CMS Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual webpage at:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>

18. Certification Statement

There are no exceptions.

C. **Collection of Information Employing Statistical Methods**

In collecting the data for payment and quality purposes, we do not employ any statistical sampling methods.

APPENDIX A:
MDS 3.0 ITEM SET V1.20.1 ASSOCIATED CHANGE TABLE

See attached MDS 3.0_Item Set Change History_v1.20.1 October 2025.pdf, titled *MDS 3.0 Item Set Change History for October 2025 Version 1.20.1*.

APPENDIX B:
GLOSSARY

ASAP: Assessment Submission and Processing
CDC: Centers for Disease Control & Prevention
CMS: Centers for Medicare & Medicaid Services
DCPAC: Division of Post-Acute and Chronic Care
DHHS: Department of Health & Human Services
FY: Fiscal Year
IOM: Institute of Medicine
IPA item set: Interim Payment Assessment item set
iQIES: Internet Quality Improvement and Evaluation System
IT: Information Technology
jRAVEN: Resident Assessment Validation and Entry System
LTC: Long-Term Care
MDS: Minimum Data Set
NC item set: Nursing Home Comprehensive assessment item set
ND item set: Nursing Home PPS Discharge item Set
NH: Nursing Home
NHSN: National Healthcare Safety Network
NO item set: Nursing Home OMRA item set
NOD item set: Nursing Home End of Therapy OMRA combined with Discharge assessment item set
NP item set: Nursing Home PPS 5-day item set
NPE item set: Nursing Home PPS Discharge item set
NQ item set: Nursing Home Quarterly item set
NQF: National Quality Forum
NS item set: Nursing Home Start of Therapy OMRA item set
NSD item set: Nursing Home Start of Therapy OMRA combined with Discharge assessment item set
NT item set: Nursing Home Tracking item set
OBRA: Omnibus Reconciliation Act of 1987
OMB: Office of Management and Budget
OMRA: Other Medicare Required Assessment
OSCAR: On-Line Survey and Certification System
PDPM: Patient Driven Payment Model
PHE: Public Health Emergency
PPS: Prospective Payment System
PRA: Paperwork Reduction Act
QIES: Quality Improvement and Evaluation System
QRP: Quality Reporting Program
RAI: Resident Assessment Instrument

RN: Registered Nurse

SD item set: Swing Bed PPS Discharge item set

SNF: Skilled Nursing Facility

SO item set: Swing Bed OMRA item set

SOD item set: Swing Bed End of Therapy OMRA combined with Discharge assessment item set

SP item set: Swing Bed PPS 5-day item set

SS item set: Swing Bed Start of Therapy OMRA item set

SSD item set: Swing Bed Start of Therapy OMRA combined with Discharge assessment item set

ST item set: Swing Bed Tracking item set

TOH Information: Transfer of Health Information

UB-04: Universal Bill Form 04