DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1827–F]

RIN 0938–AV47

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026

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

ACTION: Final rule.

SUMMARY: This final rule finalizes changes and updates to the policies and payment rates used under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for fiscal year 2026. This final rule also updates the requirements for the SNF Quality Reporting Program and the SNF Value-Based Purchasing Program.

DATES: These regulations are effective on October 1, 2025.

FOR FURTHER INFORMATION CONTACT:

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

Heidi Magladry, (410) 786–6034, for information related to the skilled nursing facility quality reporting program.

Christopher Palmer, (410) 786–8025, for information related to the skilled nursing facility value-based purchasing program.

SUPPLEMENTARY INFORMATION:

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

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

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

I. Executive Summary

A. Purpose

This final rule will update the Skilled Nursing Facility (SNF) prospective payment rates for fiscal year (FY) 2026, as required under section 1888(e)(4)(E) of the Social Security Act (the Act). It also implements section 1888(e)(4)(H) of the Act, which requires the Secretary to publish specified information relating to the payment update (see section II.C. of this final rule) in the **Federal Register** before the August 1 that precedes the start of each FY. In this final rule, we finalize several technical revisions to the code mappings used to classify patients under the Patient Driven Payment Model (PDPM) to improve payment and coding accuracy. This final rule updates requirements for the SNF Quality Reporting Program (QRP) including the removal of four standardized patient assessment data elements under the Social Determinants of Health (SDOH) category. We also amend and codify our reconsideration policy and process related to non-compliance determinations that a SNF has not met QRP reporting requirements. In addition, we provide a summary of the comments received on three Requests for Information (RFIs) for the SNF QRP, specifically on future measure concepts for the SNF QRP, potential revisions to the data submission deadlines for assessment data collected for the SNF QRP, and advancing digital quality measurement in SNFs. Finally, this final rule updates the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, including providing final performance standards, removing the Health Equity Adjustment from the Program's scoring methodology, applying the Program's scoring methodology to the Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure, adopting a new reconsideration process that will allow SNFs to appeal the Centers for Medicare & Medicaid Services (CMS) decisions on review and correction requests, and finalizing technical updates to the SNF VBP Program's regulations text. Also, for the SNF VBP Program, we are finalizing our proposal to remove the Health Equity Adjustment in the Program's scoring methodology.

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and (e)(5) of the Act, this final rule updates the annual rates that we published in the SNF PPS final rule for FY 2025 (89 FR 64048). In addition, this final rule includes a forecast error adjustment for FY 2026. We are also finalizing several technical revisions to the code mappings used to classify patients under the PDPM to improve payment and coding accuracy.

For the SNF QRP, we are finalizing our proposal to remove four standardized patient assessment data elements under the SDOH category beginning with residents admitted on October 1, 2025, for the FY 2027 SNF QRP. Additionally, we are finalizing our proposals to amend and codify our reconsideration request policy and process. Finally, we are summarizing comments received in response to three Requests for Information (RFIs) for the SNF QRP on future measure concepts for the SNF QRP, potential revisions to the data submission deadlines for assessment data collected for the SNF QRP from 4.5 months after the end of each quarter to 45 days after the end of each quarter, and advancing digital quality measurement in SNFs.

For the SNF VBP Program, we are finalizing several updates. First, we are providing final performance standards for the FY 2028 and FY 2029 program years to comply with the Program's statutory notice deadline. Second, we are applying the previously finalized scoring methodology codified at 42 CFR 413.338(e)(1) and 413.338(e)(3) of our regulations to the SNF WS PPR measure beginning with the FY 2028 program year, which is the first year that measure will be used in the SNF VBP Program's measure set (88 FR 53280). Third, we are finalizing our proposal to remove the Health Equity Adjustment to simplify the scoring methodology and provide clearer incentives for SNFs as they seek to improve their quality of care for all residents. Fourth, we are finalizing our proposal to adopt a reconsideration process that will allow SNFs to seek reconsideration of a review and correction request if they are not satisfied with CMS's decision on that request, beginning with the FY 2027 program year. Lastly, we are finalizing our proposal to adopt several updates to the SNF VBP Program's regulations text to align with finalized policies.

C. Summary of Cost and Benefits

TABLE 1: Estimated Cost and Benefits

Updates	Estimated Total Transfers/Costs
FY 2026 SNF PPS payment rate update	The overall economic impact of this final is an estimated increase of $1.16 billion in aggregate payments to SNFs during FY 2026.
FY 2027 SNF QRP changes due to the Removal of Four Standardized Patient Assessment Data Elements	The overall economic impact of this final rule to SNFs is an estimated decrease of $2.2 million annually to SNFs beginning with the FY 2027 SNF QRP.
FY 2027 SNF QRP changes due to the Amendment of the Reconsideration Request Policy and Process for those SNF's requesting an extension to file a request for reconsideration	The overall economic impact of this final rule to those SNFs requesting an extension to file a request for reconsideration is an estimated increase of $2,391.90 annually.
FY 2026 SNF VBP changes	The overall economic impact of the SNF VBP Program is an estimated reduction of $208.36 million in aggregate payments to SNFs during FY 2026.
FY 2027 SNF VBP changes	The overall economic impact of the SNF VBP Program is an estimated reduction of $207.99 million in aggregate payments to SNFs during FY 2027.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA 1997) (Pub. L. 105–33, enacted August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for SNFs. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers virtually all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Medicare Part A, as well as those items and services (other than a small number of excluded services, such as physicians' services) for which payment may otherwise be made under Medicare Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Medicare Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998, interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_2018-10-01.pdf.*

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

B. Initial Transition for the SNF PPS

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

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in a final rule that set forth updates to the SNF PPS payment rates for FY 2025 (89 FR 64048), as amended by the subsequent correction notice (89 FR 80132).

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

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

Along with other revisions discussed in the proposed rule, this final rule will set out the required annual updates to the per diem payment rates for SNFs for FY 2026.

III. SNF PPS Rate Setting Methodology and FY 2026 Payment Update

A. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem Federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporated a Medicare Part B add-on, which is an estimate of the amounts that, prior to the SNF PPS, would be payable under Medicare Part B for covered SNF services furnished to individuals during the course of a covered Medicare Part A stay in a SNF.

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

B. SNF Market Basket Update

1. SNF Market Basket

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

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

As outlined in the proposed rule, we proposed a FY 2026 SNF market basket percentage increase of 3.0 percent based on IHS Global Inc.'s (IGI's) fourth-quarter 2024 forecast of the 2022-based SNF market basket (before application of the forecast error adjustment and productivity adjustment). We also proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket, the productivity adjustment, and/or the forecast error adjustment), we would use such data, if appropriate, to determine the FY 2026 SNF market basket percentage increase, labor-related share relative importance, forecast error adjustment, or productivity adjustment in the SNF PPS final rule.

Since the proposed rule, we have updated the FY 2026 SNF market basket percentage increase based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025. The FY 2026 growth rate of the 2022-based SNF market basket is estimated to be 3.3 percent.

2. Market Basket Update Factor for FY 2026

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage increase as the percentage change in the SNF market basket from the midpoint of the previous FY to the midpoint of the current FY. For the Federal rates outlined in this final rule, we use the percentage change in the SNF market basket to compute the update factor for FY 2026. This factor is based on the FY 2026 percentage increase in the 2022-based SNF market basket reflecting routine, ancillary, and capital-related expenses. Sections 1888(e)(4)(E)(ii)(IV) and (e)(5)(B)(i) of the Act require that the update factor used to establish the FY 2026 unadjusted Federal rates be at a level equal to the SNF market basket percentage increase. Accordingly, we determined the total growth from the average market basket level for the period of October 1, 2024, through September 30, 2025, to the average market basket level for the period of October 1, 2025, through September 30, 2026. As outlined in the proposed rule, we proposed a FY 2026 SNF market basket percentage increase of 3.0 percent. For this final rule, based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025, the FY 2026 growth rate of the 2022-based SNF market basket is estimated to be 3.3 percent.

As further explained in section IV.B.3. of this final rule, as applicable, we adjusted the percentage increase by the forecast error adjustment from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage increase in the market basket exceeds a 0.5 percentage point threshold in absolute terms. Additionally, section 1888(e)(5)(B)(ii) of the Act requires us to reduce the market basket percentage increase by the productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business total factor productivity (TFP) for the period ending September 30, 2026), which is estimated to be 0.7 percentage point, as described in section IV.B.4. of this final rule.

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

The following is a summary of the public comments received on the proposed FY 2026 SNF market basket percentage increase to the SNF PPS rates, along with our responses.

Comment: The Medicare Payment Advisory Commission (MedPAC)

commented that while they understand that the law requires CMS to update the SNF PPS rates by the market basket minus a productivity adjustment, MedPAC recommended in its March 2025 Report to Congress that the Congress should reduce the SNF base payment rates by 3 percent for FY 2026. MedPAC's payment adequacy analyses indicated that not including federal relief funds, the aggregate FFS Medicare margin for freestanding SNFs in 2023 was 22 percent, the 24th consecutive year that this margin has exceeded 10 percent. MedPAC stated that these high margins indicate that a reduction is needed to more closely align aggregate payments to aggregate costs, and that even though CMS is required by law to update the payment rates each year by the estimated change in the market basket reduced by the productivity adjustment, the agency is not required to make automatic forecast-error corrections.

Response: We thank MedPAC for their recommendation and agree that current law requires us to update SNF PPS payments by the market basket percentage increase reduced by a productivity adjustment, as directed by sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5)(B)(ii) of the Act. We discuss our application of a forecast error correction in section IV.B.3 of this final rule.

Comment: Many commenters stated that they appreciate the proposed 3.0 percent market basket percentage increase for FY 2026; however, several commenters noted that they have reservations about the adequacy of the increase. Multiple interested parties characterized the proposed increase as insufficient to address the current economic pressures confronting skilled nursing facilities nationwide.

Commenters cited persistent inflationary pressures, escalating operational expenses, and ongoing workforce shortages that continue to create financial strain across the post-acute care sector. They noted cost pressures across all dimensions of SNF operations, encompassing the cost of labor, drugs, medical and non-medical supplies, utilities, food services, insurance, and other essential operational expenses. Commenters also stated that these rising costs are anticipated to continue with the implementation of various regulations and economic policies, including tariff increases. Additionally, the requirement for Enhanced Barrier Precautions, which require glove and gown use during high contact resident care activities for residents that are known to have history of multi-drug-resistant organisms, has driven up supply costs, while the reporting of infections to the national health and safety network is driving up administrative costs. Three commenters supported and appreciated the proposed net payment update, which they believed appropriately reflects changes over time in prices of mixed goods and services.

Multiple commenters expressed concern that the current market basket methodology consistently produces SNF PPS updates that are inadequate because the methodology fails to fully account for cost growth pressures during periods of elevated inflation. One commenter stated that the Employment Cost Index (ECI) used to measure changes in labor compensation in the SNF market basket might not fully capture growth in employment and labor costs, as it does not account for changes driven by shifts between different categories of labor. Commenters recommended that CMS reevaluate its market basket methodology to ensure more precise reflection of expected growth in SNFs' costs for both labor and goods and services.

Response: We appreciate the comments regarding the proposed FY 2026 SNF PPS market basket update. The 2022-based SNF market basket is a fixed-weight, Laspeyres-type price index that measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to a base period are not measured. The proposed FY 2026 SNF market basket percentage increase of 3.0 percent reflected the most-recent forecast available at the time of rulemaking. As stated in the SNF PPS proposed rule for FY 2026 (90 FR 18593), we proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket and/or the productivity adjustment), we would use such data, if appropriate, to determine the FY 2026 SNF market basket percentage increase, labor-related share relative importance, forecast error adjustment, or productivity adjustment in the SNF PPS final rule.

Since the SNF market basket update is required to be set prospectively, it relies on a mix of historical data for part of the period for which the update is calculated and forecasted data for the remainder. As a result, the market basket percentage increase reflects expectations of trends, which may periodically differ from actual experience due to unforeseen events. The forecasted data are provided by IHS Global Inc. (IGI),[1] a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets. For this final rule, we have incorporated the most recent historical data and forecasts provided by IGI to capture the expected price and wage pressures facing SNFs in FY 2026. The FY 2026 market basket update in this final rule reflects historical data through the first quarter of 2025 and forecasted data through the third quarter of 2026. The final FY 2026 market basket update is higher than in the proposed rule due to economic uncertainty.

Concerning the use of the ECI to measure changes in labor compensation in the market basket, we believe that the ECI for Wages and Salaries for Private Industry Workers in Nursing Care Facilities is accurately reflecting the price change associated with the labor used to provide SNF care. The ECI appropriately does not reflect other factors that might affect the rate of price changes associated with labor costs, such as a shift in the occupations that may occur due to increases in case-mix or shifts in purchasing decisions (for instance, to hire or to use contract labor). We believe that the prices of employed staff and contract labor are influenced by the same factors and should generally grow at similar rates. For this final rule, based on the more recent IGI second quarter 2025 forecast with historical data through the first quarter of 2025, the projected 2022-based SNF market basket increase factor for FY 2026 reflects a projected increase in compensation prices of 3.3 percent.

Based on IGI's second quarter 2025 forecast with historical data through first-quarter 2025, the FY 2026 growth rate of the 2022-based SNF market basket is 3.3 percent. By incorporating the most recent estimates available of the market basket percentage increase, we believe these data reflect the best available projection of input price inflation faced by SNFs in FY 2026.

After consideration of the comments received on the FY 2026 SNF market basket proposals, we are finalizing a FY 2026 SNF market basket percentage increase of 3.3 percent (prior to the application of the forecast error adjustment and productivity adjustment, which are discussed later in this section).

3. Forecast Error Adjustment

As discussed in the June 10, 2003, supplemental proposed rule (68 FR 34768) and finalized in the August 4,

[1] *www.spglobal.com.*

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

Table 2 provides the forecast error adjustments applicable to the FY SNF PPS updates for FY 2016 through FY 2026. The forecast error adjustments would be based on the SNF market basket percentage increase for two years prior to the FY SNF PPS update (the most recently available FY for which there is final data at the time of rate setting).

TABLE 2: Forecast Error Adjustments Applicable to the FY SNF PPS Updates

	FY 2016	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
Forecast Error Adjustment	**-0.6**	**-0.8**	**+1.5**	**+3.6**	**+1.7**	**+0.6**

*Any years not shown indicate that in the most recent FY for which there was final data, the SNF forecast error did not exceed the 0.5 percentage point threshold established in regulation for forecast error adjustment.

For FY 2024 (the most recently available FY for which there is final data), the forecasted or estimated increase in the SNF market basket was 3.0 percent, and the actual increase for FY 2024 was 3.6 percent, resulting in the actual increase being 0.6 percentage point higher than the estimated increase. Accordingly, as the difference between the estimated and actual percentage increase in the market basket exceeds the 0.5 percentage point threshold, under the policy previously described (comparing the forecasted and actual market basket percentage increase), the FY 2026 market basket percentage increase of 3.3 percent is adjusted upward to account for the forecast error adjustment of 0.6 percentage point, resulting in a FY 2026 SNF market basket percentage increase of 3.9 percent, which is then reduced by the productivity adjustment of 0.7 percentage point, discussed in section III.B.4.A of this final rule. This results in a SNF market basket update for FY 2026 of 3.2 percent.

Table 3 shows the forecasted and actual market basket percentage increases for FY 2024.

TABLE 3: Difference Between the Actual and Forecasted SNF Market Basket Percentage Increases for FY 2024

Index	Forecasted FY 2024 Percentage Increase*	Actual FY 2024 Percentage Increase**	FY 2024 Difference
SNF	3.0	3.6	0.6

*Published in **Federal Register**; based on second quarter 2023 IHS Global Inc. forecast (2018-based SNF market basket).

** Based on the second quarter 2025 IHS Global Inc. forecast (2018-based SNF market basket), with historical data through first quarter 2025.

The following is a summary of the public comments received on the forecast error adjustment, along with our responses.

Comment: Multiple commenters expressed concerns about both the timing and adequacy of the forecast error correction mechanism as currently implemented. Commenters noted that the forecast error correction is applied with a 2-year delay, creating operational and financial challenges for providers who must manage immediate cost pressures without adequate compensation during the intervening period.

A few commenters noted that this lagged approach does not fully compensate for the inaccurate projection because CMS does not apply additional inflation adjustments to the error correction itself, thereby compounding the negative financial impact on providers over time. They indicated that, as a result, the current methodology may create a systematic underpayment.

A few commenters recommended that CMS consider implementing more responsive and dynamic mechanisms to address inflation in real-time or near real-time, rather than relying exclusively on retrospective adjustments that may inadequately compensate for the immediate and ongoing financial pressures facing SNFs. Some commenters suggested that CMS should consider implementing prospective percentage add-ons or alternative adjustment mechanisms to more accurately reflect the impact of wage and benefit cost increases, particularly given the ongoing effects of workforce challenges and new

regulatory requirements that may further increase operational costs.

Several commenters recommended that CMS conduct a thorough evaluation of whether the current 0.5 percentage point threshold for triggering forecast error adjustments remains appropriate given the increased volatility in healthcare costs and inflation rates experienced in recent years.

One commenter questioned what assumptions underlie the proposed FY 2026 forecast error adjustment and whether those assumptions are consistent with past model performance and inflation volatility.

MedPAC noted that not including federal relief funds, the aggregate FFS Medicare margin for freestanding SNFs in 2023 was 22 percent, the 24th consecutive year that this margin has exceeded 10 percent. They stated that the high margins indicate that a reduction is needed to more closely align aggregate payments to aggregate costs, and that while CMS is required by statute to update the payment rates each year by the estimated change in the market basket reduced by the productivity adjustment, the agency is not required to make automatic forecast error corrections.

Response: We refer readers to the FY 2004 SNF PPS final rule (68 FR 46058) for a discussion of our rationale for applying a forecast error correction. Regarding other comments, we understand that earlier forecast error adjustments might be preferable, but a 2-year lag is necessary because historical data for the current FY are not available until after the following year's update is determined. Additionally, while we recognize the appeal of alternative approaches such as prospective adjustments during periods of economic volatility, this would have the potential to introduce more variable and unstable updates. As noted by commenters, the threshold at which forecast error adjustments are triggered is 0.5 percentage point, which is intended to distinguish typical statistical variances from more major unanticipated impacts.

For the FY 2026 SNF PPS update, we proposed a forecast error adjustment of 0.6 percentage point to account for the difference between the FY 2024 forecasted increase in the 2018-based SNF market basket (3.0 percent) and the actual increase in the 2018-based SNF market basket (3.6 percent)—as the difference between the estimated and actual percentage increase in the market basket exceeds the 0.5 percentage point threshold. The FY 2024 forecast error is mostly attributable to compensation prices (as measured by the ECIs for Private Industry Workers in Nursing Care Facilities), which account for about 60 percent of the SNF market basket. IGI projected the FY 2024 compensation prices would increase 3.4 percent (notably slower than the average price growth of 6.5 percent for 2022 and 2023) but slightly higher than the average of 3.3 percent over the 2014 to 2023 time period. Actual FY 2024 compensation prices increased 4.3 percent. The compensation prices forecast error was partially offset by pharmaceutical prices, which IGI had projected to increase 2.2 percentage points faster than the actual historical data.

When developing its forecast for the ECI for Private Industry Workers in Nursing Care Facilities, IGI considers overall economic factors (such as overall inflation and labor market conditions that included a rise in contract labor employment due to tight labor market conditions) as well as industry-specific factors (including the skill mix of the staff and the impact of minimum wage laws). IGI noted that overall inflation was higher than expectations in 2024 with growth of 3.0 percent compared to projected growth of 2.5 percent. Overall strong economic growth and strong job creation kept labor markets tight. In addition, in October 2023 (3 months after the publication of the SNF FY 2024 final rule), California passed S.B. 525 (October 13, 2023) that lifted the minimum wage for healthcare workers.[2]

After consideration of the comments received, we are finalizing the application of the proposed forecast error adjustment without modification. As stated previously in this section, based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025, the FY 2026 growth rate of the 2022-based SNF market basket is estimated to be 3.3 percent. Accordingly, as the difference between the FY 2024 forecasted and actual percentage change in the market basket exceeds the 0.5 percentage point threshold, under the policy previously described (comparing the forecasted and actual market basket percentage increase), the FY 2026 market basket percentage increase of 3.3 percent is adjusted upward to account for the forecast error adjustment of 0.6 percentage point.

4. Productivity Adjustment

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

The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measure of productivity for the Unites States. We note that previously the productivity measure referenced at section 1886(b)(3)(B)(xi)(II) of the Act was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021, release of productivity data, BLS replaced the term MFP with TFP. BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as private nonfarm business total factor productivity. We refer readers to the BLS website at *www.bls.gov* for the BLS historical published TFP data. A complete description of the TFP projection methodology is available on our website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.* In addition, in the FY 2022 SNF final rule (86 FR 42429) we noted that, effective with FY 2022 and forward, we changed the name of this adjustment to refer to it as the ''productivity adjustment,'' rather than the ''MFP adjustment.''

Section 1888(e)(5)(A) of the Act, the Secretary shall establish a SNF market basket that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, the Secretary shall reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)

[2] *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB525.*

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

Based on the data available for the FY 2026 SNF PPS proposed rule, the proposed productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business TFP for the period ending September 30, 2026) was projected to be 0.8 percentage point.

The following is a summary of the public comments received on the productivity adjustment, along with our responses.

Comment: We received numerous comments regarding the proposed 0.8 percentage point productivity adjustment, with multiple interested parties expressing concerns about both the magnitude of this reduction and the underlying methodology used to calculate the adjustment. One commenter noted that the proposed productivity adjustment represents a significant increase compared to prior years, further reducing the SNF PPS net payment update at a time when providers are confronting unprecedented cost pressures and operational challenges across multiple dimensions of their operations. One commenter stated that it is puzzling how an indicator based on a 10-year moving average could yield such an increase in the productivity adjustment from FY 2025 to FY 2026; however, the commenter stated they were unable to fully analyze the projections due to a lack of transparency from CMS. In addition, the commenter found it troubling that the productivity adjustment is used only when it decreases Medicare payments.

Several commenters questioned the applicability of TFP to healthcare settings. One commenter referenced a 2022 CMS memorandum that outlined the CMS Office of the Actuary's analysis of the TFP methodology, noting that for the most recent 10-year moving average period, the growth of TFP for hospitals was below that observed in other private nonfarm business industries. The commenter cited specific findings indicating that hospitals' TFP ranged from 0.2 to 0.5 percent, while private nonfarm business TFP measured 0.8 percent.

Commenters stated that by incorporating private nonfarm business productivity measures in the current methodology, CMS effectively accounts for innovation and productivity improvements from diverse economic sectors that differ significantly from the productivity capabilities and constraints inherent in healthcare delivery settings, resulting in an overstated productivity adjustment that inappropriately reduces Medicare payment rate updates.

Various interested parties emphasized that healthcare providers, particularly SNFs, face unique operational constraints, regulatory requirements, quality standards, and patient safety obligations that limit their ability to achieve productivity gains comparable to other industries. Several commenters recommended that CMS undertake a comprehensive reevaluation of the productivity adjustment methodology to better reflect the actual productivity capabilities and constraints of healthcare providers, rather than applying economy-wide productivity measures that may not be achievable or appropriate in clinical care delivery settings where patient safety and quality of care must remain paramount considerations.

Response: Section 1888(e)(5)(B)(ii) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the SNF PPS market basket increase factor. As required by statute, the FY 2026 productivity adjustment is derived based on the 10-year moving average growth in economy-wide nonfarm business TFP for the period ending in FY 2026. We recognize the concerns of the commenters regarding the appropriateness of the productivity adjustment; however, we are required under section 1888(e)(5)(B)(ii) of the Act to apply the specific productivity adjustment described here.

We have always made available on the CMS website the general method for calculating the productivity adjustment. This includes providing a link to the most recent BLS historical TFP data, which allows interested parties to obtain historical TFP annual index levels for 1987 through 2024. We also provided the IGI projection model (*https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/tfp_methodology.pdf*), which is used to derive annual TFP growth rates for 2025 and 2026. The annual index level derived from this method is then interpolated to quarterly levels, and the FY 2026 productivity adjustment is equal to the percent change in the 40-quarter moving average projected level for the period ending September 30, 2026, relative to the 40-quarter moving average projected level for the period ending September 30, 2025. We believe our methodology for the productivity adjustment is consistent with section 1886(b)(3)(B)(xi)(II) of the Act, which states that the productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period).

At the time of this final rule, the FY 2026 productivity adjustment reflects BLS historical TFP data through 2024 (released on March 21, 2025) and IGI's forecasted TFP growth for 2025 and 2026. The average annual growth rate of historical TFP published by BLS for 2017 through 2024 is currently 0.9 percent and IGI is projecting average TFP growth of about 0.0 percent for 2025 and 2026 based on IGI's second quarter 2025 forecast. Combining the historical and projected TFP data over the entire 10-year time period results in a compound annual growth rate of TFP of 0.7 percent for 2026. The productivity adjustment (based on the 10-year period ending with FY 2026) for the FY 2026 final rule is 0.1 percentage point lower than in the FY 2026 proposed rule, and primarily reflects the incorporation of a revised outlook from IGI that has lower projected economic growth over 2025 and 2026. The 0.7-percent productivity adjustment in the FY 2026 final rule is larger than the productivity adjustment in the prior final rules for FY 2023 and FY 2024 mainly due to the incorporation of updated BLS historical data.

In response to commenters' concerns about the productivity adjustment only being applied if it reduces the payment update, we note that the productivity adjustment was established under the Affordable Care Act with a specific policy intent to encourage efficiency improvements in healthcare delivery by linking Medicare payment updates to economy-wide productivity gains. Section 1888(e)(5)(B)(ii) of the Act requires that the Secretary reduce (not increase) the market basket percentage increase by changes in economy-wide

productivity, therefore, only positive productivity adjustments are applied.

As stated previously, in the proposed rule the FY 2026 productivity adjustment was estimated to be 0.8 percentage point based on IGI's fourth quarter 2024 forecast. For this final rule, based on IGI's second quarter 2025 forecast, the productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business TFP for the period ending September 30, 2026) is 0.7 percentage points.

Consistent with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2), and as outlined previously in section III.B.2. of this final rule, the market basket percentage increase for FY 2026 for the SNF PPS is based on IHS Global Inc.'s second quarter 2025 forecast of the SNF market basket percentage increase, which is estimated to be 3.3 percent. This market basket percentage increase is then increased by 0.6 percentage point, due to application of the forecast error adjustment outlined earlier in section III.B.3. of this final rule. Finally, as outlined earlier in this section, we are applying a 0.7 percentage point productivity adjustment to the FY 2026 SNF market basket percentage increase. Therefore, the resulting FY 2026 SNF market basket update is equal to 3.2 percent. Thus, we apply a net SNF market basket update factor of 3.2 percent in our determination of the FY 2026 SNF PPS unadjusted Federal per diem rates.

5. Unadjusted Federal Per Diem Rates for FY 2026

As stated in the FY 2019 SNF PPS final rule (83 FR 39162), in FY 2020 we implemented a new case-mix classification system to classify SNF patients under the SNF PPS, the PDPM. As stated in section V.B.1. of that final rule (83 FR 39189), under PDPM, the unadjusted Federal per diem rates are divided into six components, five of which are case-mix adjusted components (Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA)), and one of which is a non-case-mix component, as existed under the previous Resource Utilization Groups, Version IV (RUG–IV) model. We proposed to use the SNF market basket update, adjusted as outlined previously in sections III.B.1. through III.B.4. of this final rule, to adjust each per diem component of the Federal rates forward to reflect the change in the average prices for FY 2026 from the average prices for FY 2025. We also proposed to further adjust the rates by a wage index budget neutrality factor, outlined in section III.D. of this final rule.

Further, in the past, we used the revised Office of Management and Budget (OMB) delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634), with updates as reflected in OMB Bulletin Nos. 15–01 and 17–01 to identify a facility's urban or rural status for the purpose of determining which set of rate tables apply to the facility. As discussed in the FY 2021 SNF PPS proposed and final rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) to identify a facility's urban or rural status effective beginning with FY 2021. As discussed in the FY 2025 SNF PPS proposed and final rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf)* to identify a facility's urban or rural status effective beginning with FY 2025.

Tables 4 and 5 reflect the unadjusted Federal rates for FY 2026, prior to adjustment for case-mix.

TABLE 4: FY 2026 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$75.73	$70.49	$28.28	$132.00	$99.59	$118.21

TABLE 5: FY 2026 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$86.33	$79.29	$35.63	$126.12	$95.15	$120.40

C. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the Federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. In the FY 2019 final rule (83 FR 39162, August 8, 2018), we finalized a new case-mix classification model, the PDPM, which took effect beginning October 1, 2019. The previous RUG–IV model classified most patients into a therapy payment group and primarily used the volume of therapy services provided to the patient as the basis for payment classification, thus creating an incentive for SNFs to furnish therapy regardless of the individual patient's unique characteristics, goals, or needs. PDPM eliminates this incentive and improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing the administrative burden on SNFs.

The PDPM uses clinical data from the Minimum Data Set (MDS), a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid, consistent with the provisions of section 1888(e)(4)(G)(i) of the Act. As outlined in section IV.A. of this final rule, the clinical orientation

of the case-mix classification system supports the SNF PPS's use of an administrative presumption that considers a beneficiary's initial case-mix classification to assist in making certain SNF level of care determinations. Further, because the MDS is used as a basis for payment, as well as a clinical assessment, we have provided extensive training on proper coding and the timeframes for MDS completion in our Resident Assessment Instrument (RAI) Manual. As previously stated, for an MDS to be considered valid for use in determining payment, the MDS assessment must be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS website at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.*

Under section 1888(e)(4)(H) of the Act, each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The FY 2026 payment rates set forth in this final rule reflect the use of the PDPM case-mix classification system from October 1, 2025, through September 30, 2026. The case-mix adjusted PDPM payment rates for FY 2026 are listed separately for urban and rural SNFs, in Tables 6 and 7 with corresponding case-mix values.

Given the differences between the previous RUG–IV model and PDPM in terms of patient classification and billing, it was important that the format of Tables 6 and 7 reflect these differences. More specifically, under both RUG–IV and PDPM, providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim to bill for covered SNF services. Under RUG–IV, the HIPPS code included the three-character RUG–IV group into which the patient classified, as well as a two-character assessment indicator code that represented the assessment used to generate this code. Under PDPM, while providers still use a HIPPS code, the characters in that code represent different things. For example, the first character represents the PT and OT group into which the patient classifies. If the patient is classified into the PT and OT group ''TA'', then the first character in the patient's HIPPS code would be an ''A.'' Similarly, if the patient is classified into the SLP group ''SB'', then the second character in the patient's HIPPS code would be a ''B.'' The third character represents the Nursing group into which the patient classifies. The fourth character represents the NTA group into which the patient classifies. Finally, the fifth character represents the assessment used to generate the HIPPS code.

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

Tables 6 and 7 do not reflect adjustments which may be made to the SNF PPS rates as a result of the SNF VBP Program, outlined in section V.II. of this final rule, or other adjustments, such as the variable per diem adjustment.

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TABLE 6: 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	$109.81	1.41	$99.39	0.64	$18.10	ES3	3.84	$506.88	3.06	$304.75
B	1.61	$121.93	1.54	$108.55	1.72	$48.64	ES2	2.90	$382.80	2.39	$238.02
C	1.78	$134.80	1.60	$112.78	2.52	$71.27	ES1	2.77	$365.64	1.74	$173.29
D	1.81	$137.07	1.45	$102.21	1.38	$39.03	HDE2	2.27	$299.64	1.26	$125.48
E	1.34	$101.48	1.33	$93.75	2.21	$62.50	HDE1	1.88	$248.16	0.91	$90.63
F	1.52	$115.11	1.51	$106.44	2.82	$79.75	HBC2	2.12	$279.84	0.68	$67.72
G	1.58	$119.65	1.55	$109.26	1.93	$54.58	HBC1	1.76	$232.32	-	-
H	1.10	$83.30	1.09	$76.83	2.7	$76.36	LDE2	1.97	$260.04	-	-
I	1.07	$81.03	1.12	$78.95	3.34	$94.46	LDE1	1.64	$216.48	-	-
J	1.34	$101.48	1.37	$96.57	2.83	$80.03	LBC2	1.63	$215.16	-	-
K	1.44	$109.05	1.46	$102.92	3.50	$98.98	LBC1	1.35	$178.20	-	-
L	1.03	$78.00	1.05	$74.01	3.98	$112.55	CDE2	1.77	$233.64	-	-
M	1.20	$90.88	1.23	$86.70	-	-	CDE1	1.53	$201.96	-	-
N	1.40	$106.02	1.42	$100.10	-	-	CBC2	1.47	$194.04	-	-
O	1.47	$111.32	1.47	$103.62	-	-	CA2	1.03	$135.96	-	-
P	1.02	$77.24	1.03	$72.60	-	-	CBC1	1.27	$167.64	-	-
Q	-	-	-	-	-	-	CA1	0.89	$117.48	-	-
R	-	-	-	-	-	-	BAB2	0.98	$129.36	-	-
S	-	-	-	-	-	-	BAB1	0.94	$124.08	-	-
T	-	-	-	-	-	-	PDE2	1.48	$195.36	-	-
U	-	-	-	-	-	-	PDE1	1.39	$183.48	-	-
V	-	-	-	-	-	-	PBC2	1.15	$151.80	-	-
W	-	-	-	-	-	-	PA2	0.67	$88.44	-	-
X	-	-	-	-	-	-	PBC1	1.07	$141.24	-	-
Y	-	-	-	-	-	-	PA1	0.62	$81.84	-	-

TABLE 7: 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	$125.18	1.41	$111.80	0.64	$22.80	ES3	3.84	$484.30	3.06	$291.16
B	1.61	$138.99	1.54	$122.11	1.72	$61.28	ES2	2.90	$365.75	2.39	$227.41
C	1.78	$153.67	1.60	$126.86	2.52	$89.79	ES1	2.77	$349.35	1.74	$165.56
D	1.81	$156.26	1.45	$114.97	1.38	$49.17	HDE2	2.27	$286.29	1.26	$119.89
E	1.34	$115.68	1.33	$105.46	2.21	$78.74	HDE1	1.88	$237.11	0.91	$86.59
F	1.52	$131.22	1.51	$119.73	2.82	$100.48	HBC2	2.12	$267.37	0.68	$64.70
G	1.58	$136.40	1.55	$122.90	1.93	$68.77	HBC1	1.76	$221.97	-	-
H	1.10	$94.96	1.09	$86.43	2.7	$96.20	LDE2	1.97	$248.46	-	-
I	1.07	$92.37	1.12	$88.80	3.34	$119.00	LDE1	1.64	$206.84	-	-
J	1.34	$115.68	1.37	$108.63	2.83	$100.83	LBC2	1.63	$205.58	-	-
K	1.44	$124.32	1.46	$115.76	3.50	$124.71	LBC1	1.35	$170.26	-	-
L	1.03	$88.92	1.05	$83.25	3.98	$141.81	CDE2	1.77	$223.23	-	-
M	1.20	$103.60	1.23	$97.53	-	-	CDE1	1.53	$192.96	-	-
N	1.40	$120.86	1.42	$112.59	-	-	CBC2	1.47	$185.40	-	-
O	1.47	$126.91	1.47	$116.56	-	-	CA2	1.03	$129.90	-	-
P	1.02	$88.06	1.03	$81.67	-	-	CBC1	1.27	$160.17	-	-
Q	-	-	-	-	-	-	CA1	0.89	$112.25	-	-
R	-	-	-	-	-	-	BAB2	0.98	$123.60	-	-
S	-	-	-	-	-	-	BAB1	0.94	$118.55	-	-
T	-	-	-	-	-	-	PDE2	1.48	$186.66	-	-
U	-	-	-	-	-	-	PDE1	1.39	$175.31	-	-
V	-	-	-	-	-	-	PBC2	1.15	$145.04	-	-
W	-	-	-	-	-	-	PA2	0.67	$84.50	-	-
X	-	-	-	-	-	-	PBC1	1.07	$134.95	-	-
Y	-	-	-	-	-	-	PA1	0.62	$78.19	-	-

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D. Wage Index Adjustment

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. We will continue this practice for FY 2026, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data under the inpatient prospective payment system (IPPS) also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. As in previous years, we proposed to continue to use the pre-reclassified IPPS hospital wage data, without applying the occupational mix, rural floor, or outmigration adjustment, as the basis for the SNF PPS wage index. For FY 2026, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2021, and before October 1, 2022 (FY 2022 cost report data).

Section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted December 21, 2000) gave the Secretary the discretion to establish a geographic reclassification procedure specific to SNFs, but only after collecting the data necessary to establish a SNF PPS wage index that is based on wage data from nursing homes. To date, this has proven to be unfeasible, due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of the data. More specifically, auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors (MACs), potentially far in excess of those required under the IPPS, given that there are nearly five times as many SNFs as there are inpatient hospitals. While we do not believe this undertaking is feasible at this time, we will continue to explore implementation of a spot audit process to improve SNF cost reports to ensure they are adequately accurate for cost development purposes, in such a manner as to permit us to establish a SNF-specific wage index in the future. We will continue to monitor the appropriateness of using the hospital data as a proxy, and make adjustments in future rulemaking if we identify a better approach to the wage index.

In addition, we continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in

which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2026 SNF PPS wage index. For rural geographic areas that do not have hospitals and therefore lack hospital wage data on which to base an area wage adjustment, we will continue using the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For FY 2026, the only rural area without wage index data available is North Dakota. For urban areas without specific hospital wage index data, we will continue using the average wage indexes of all urban areas within the State of North Dakota to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2026, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

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

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

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

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

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

On July 21, 2023, OMB issued OMB Bulletin No. 23–01, which updates and supersedes OMB Bulletin No. 20–01 based on the decennial census. OMB Bulletin No. 23–01 revised delineations for CBSAs which are made up of counties and equivalent entities (for example, boroughs; a city and borough, and a municipality in Alaska; planning regions in Connecticut; parishes in Louisiana; municipios in Puerto Rico; and independent cities in Maryland, Missouri, Nevada, and Virginia). As stated in the FY 2025 SNF PPS final rule (89 FR 64059), we adopted the revised OMB delineations identified in OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*). OMB has not published further delineation revisions since OMB Bulletin No. 23–01. Therefore, for FY 2026, we proposed to maintain the current CBSA delineations. The wage index applicable to FY 2026 is set forth in Table A and B, available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

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

PPS final rule (89 FR 64080 through 64081).

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related share of the total costs after taking into account historical and projected price changes between the base year and FY 2026. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2026 than the base year weights from the SNF market basket. We calculate the labor-related relative importance for FY 2026 in four steps. First, we compute the FY 2026 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2026 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2026 relative importance for each cost category by multiplying this ratio by the base year (2022) weight. Finally, we add the FY 2026 relative importance for each of the labor-related cost categories (Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services; and a portion of Capital-Related expenses) to produce the proposed FY 2026 labor-related relative importance.

For the proposed rule, the proposed labor-related share for FY 2026 was 71.9 percent and was based on IGI's fourth quarter 2024 forecast of the 2022-based SNF market basket with historical data through third-quarter 2024. We also proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket, the productivity adjustment, and/or the forecast error adjustment), we would use such data, if appropriate, to determine the FY 2026 SNF market basket percentage increase, labor-related share relative importance, forecast error adjustment, or productivity adjustment in the SNF PPS final rule (90 FR 18593). For this final rule, as proposed, we estimate the labor-related share for FY 2026 to be 71.9 percent based on IGI's more recent second quarter 2025 forecast, with historical data through the first quarter of 2025. Table 8 summarizes the labor-related share for FY 2026, based on IGI's second quarter 2025 forecast of the 2022-based SNF market basket, compared to the labor-related share that was used for the FY 2025 SNF PPS final rule.

TABLE 8: Labor-Related Share, FY 2025 and FY 2026

	Relative importance, labor-related share, FY 2025 24:2 forecast[1]	**Relative importance, labor-related share, FY 2026 25:2 forecast[2]**
Wages and Salaries	53.2	53.4
Employee Benefits	9.2	8.9
Professional Fees: Labor-Related	3.5	3.6
Administrative & Facilities Support Services	0.4	0.4
Installation, Maintenance & Repair Services	0.5	0.5
All Other: Labor-Related Services	2.0	2.0
Capital-Related (.391* Capital RI)	3.2	3.1
Total	**72.0**	**71.9**

1. Published in the **Federal Register**; Based on the second quarter 2024 IHS Global Inc. forecast of the 2022-based SNF market basket.

2. Based on the second quarter 2025 IHS Global Inc. forecast of the 2022-based SNF market basket. The relative importance of capital for FY 2026 is forecasted to be 8.0 percent.

To calculate the labor portion of the case-mix adjusted per diem rate, we will multiply the total case-mix adjusted per diem rate, which is the sum of all five case-mix adjusted components into which a patient classifies, and the non-case-mix component rate, by the FY 2026 labor-related share percentage provided in Table 8. The remaining portion of the rate will be the non-labor portion. Under the previous RUG–IV model, we included tables which provided the case-mix adjusted RUG–IV rates, by RUG–IV group, broken out by total rate, labor portion and non-labor portion, such as Table 9 of the FY 2019 SNF PPS final rule (83 FR 39175). However, as we discussed in the FY 2020 SNF PPS final rule (84 FR 38738), under PDPM, as the total rate is calculated as a combination of six different component rates, five of which are case-mix adjusted, and given the sheer volume of possible combinations of these five case-mix adjusted components, it is not feasible to provide tables similar to those that existed in the prior rulemaking.

Therefore, to aid interested parties in understanding the effect of the wage index on the calculation of the SNF per diem rate, we have included a hypothetical rate calculation in Table 10.

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made if the wage

adjustment had not been made. For FY 2026 (Federal rates effective October 1, 2025), we apply an adjustment to fulfill the budget neutrality requirement. We meet this requirement by multiplying each of the components of the unadjusted Federal rates by a budget neutrality factor, equal to the ratio of the weighted average wage adjustment factor for FY 2025 to the weighted average wage adjustment factor for FY 2026. For this calculation, we will use the same FY 2024 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor portion of the rate component multiplied by the wage index plus the non-labor portion of the rate component. The budget neutrality factor for FY 2026 is 1.0018.

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

The following is a summary of the public comments received on the wage index and labor-related share along with our responses.

Comment: One commenter supported CMS's proposal to decrease the labor-related share of the standard rate from 72.0 percent for FY 2025 to 71.9 percent for FY 2026, while another commenter expressed concern about the effect of the wage index and labor-related share on payment.

Response: We appreciate the commenters' support and concern regarding the change in the labor-related share. We believe it continues to be technically appropriate to use the 2022-based SNF market basket labor-related relative importance to determine the labor-related share for FY 2026 as it is based on more recent data regarding price pressures and cost structure of SNFs. The labor-related relative importance is calculated from the SNF market basket and approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2026. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes.

Comment: Commenters stated support of the permanent 5-percent cap on wage index decreases. Although there were no OMB reclassifications in the proposed rule for FY 2026, the FY 2025 updates created substantial variability in the net reimbursement rates.

Response: We appreciate the commenters' support of the permanent cap on wage index decreases.

Comment: While commenters support the current wage index methodology for FY 2026, others encourage CMS to continue to reform the wage index policies (for example, SNF-specific wage index utilizing SNF audited cost report and nursing wage data or basing wage index updates on more recent data). One commenter supported the continued use of hospital inpatient wage data that provides a more stable and comprehensive reflection of labor costs, particularly in areas where wage data specific to SNFs may be limited or inconsistent.

Response: We appreciate the commenters' support of the proposed wage index policies for FY 2026. In the absence of a SNF-specific wage index, we believe the use of the pre-reclassified and pre-floor hospital wage data (without the occupational mix adjustment) continue to be an appropriate and reasonable proxy for the SNF PPS. For a detailed discussion of the rationale for our current wage index policies and for responses to these recurring comments, we refer readers to the FY 2023 SNF PPS final rule (87 FR 47513 through 47516) and the FY 2016 SNF PPS final rule (80 FR 46401 through 46402).

After consideration of public comments, we are finalizing our proposal to continue to use the updated pre-reclassification and pre-floor IPPS wage index data to develop the FY 2026 SNF PPS wage index.

E. SNF Value-Based Purchasing Program

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

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

F. Adjusted Rate Computation Example

Tables 9 through 11 provide examples generally illustrating payment calculations during FY 2026 under PDPM for a hypothetical 30-day SNF stay, involving the hypothetical SNF XYZ, located in Frederick, MD (Urban CBSA 23224), for a hypothetical patient who is classified into such groups that the patient's HIPPS code is NHNC1. Table 9 shows the adjustments made to the Federal per diem rates (prior to application of any adjustments under the SNF VBP Program as discussed) to compute the provider's case-mix adjusted per diem rate for FY 2026, based on the patient's PDPM classification, as well as how the variable per diem (VPD) adjustment factor affects calculation of the per diem rate for a given day of the stay. Table 10 shows the adjustments made to the case-mix adjusted per diem rate from Table 9 to account for the provider's wage index. The wage index used in this example is based on the FY 2026 SNF PPS wage index that appears in Table 9 available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Finally, Table 11 provides the case-mix and wage index adjusted per-diem rate for this patient for each day of the 30-day stay, as well as the total payment for this stay. Table 11 also includes the VPD adjustment factors for each day of the patient's stay, to clarify why the patient's per diem rate changes for certain days of the stay. As illustrated in Table 11, SNF XYZ's total PPS payment for this particular patient's stay would equal $23,570.65.

TABLE 9: PDPM Case-Mix Adjusted Rate Computation Example

Per Diem Rate Calculation				
Component	**Component Group**	**Component Rate**	**VPD Adjustment Factor**	**VPD Adj. Rate**
PT	N	$106.02	1.00	$106.02
OT	N	$100.10	1.00	$100.10
SLP	H	$76.36	1.00	$76.36
Nursing	N	$194.04	1.00	$194.04
NTA	C	$173.29	3.00	$519.87
Non-Case-Mix	-	$118.21	-	$118.21
Total PDPM Case-Mix Adj. Per Diem				$1,114.60

TABLE 10: Wage Index Adjusted Rate Computation Example

PDPM Wage Index Adjustment Calculation						
HIPPS Code	**PDPM Case-Mix Adjusted Per Diem**	**Labor Portion**	**Wage Index**	**Wage Index Adjusted Rate**	**Non-Labor Portion**	**Total Case Mix and Wage Index Adj. Rate**
NHNC1	$1,114.60	$801.40	0.9736	$780.24	$313.20	$1,093.44

TABLE 11: Adjusted Rate Computation Example

Day of Stay	NTA VPD Adjustment Factor	PT/OT VPD Adjustment Factor	Case Mix and Wage Index Adjusted Per Diem Rate
1	3.0	1.0	$1,093.44
2	3.0	1.0	$1,093.44
3	3.0	1.0	$1,093.44
4	1.0	1.0	$753.44
5	1.0	1.0	$753.44
6	1.0	1.0	$753.44
7	1.0	1.0	$753.44
8	1.0	1.0	$753.44
9	1.0	1.0	$753.44
10	1.0	1.0	$753.44
11	1.0	1.0	$753.44
12	1.0	1.0	$753.44
13	1.0	1.0	$753.44
14	1.0	1.0	$753.44
15	1.0	1.0	$753.44
16	1.0	1.0	$753.44
17	1.0	1.0	$753.44
18	1.0	1.0	$753.44
19	1.0	1.0	$753.44
20	1.0	1.0	$753.44
21	1.0	0.98	$749.40
22	1.0	0.98	$749.40
23	1.0	0.98	$749.40
24	1.0	0.98	$749.40
25	1.0	0.98	$749.40
26	1.0	0.98	$749.40
27	1.0	0.98	$749.40
28	1.0	0.96	$745.35
29	1.0	0.96	$745.35
30	1.0	0.96	$745.35
Total Payment			$23,570.65

IV. Additional Aspects of the SNF PPS

A. SNF Level of Care—Administrative Presumption

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

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

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

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. The FY 2018 final rule (82 FR 36544) further specified that we would henceforth disseminate the standard description of the administrative presumption's designated groups via the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/*

index.html (where such designations appear in the paragraph entitled ''Case Mix Adjustment'') and would publish such designations in rulemaking only to the extent that we actually intend to propose changes in them. Under that approach, the set of case-mix classifiers designated for this purpose under PDPM was finalized in the FY 2019 SNF PPS final rule (83 FR 39253) and is posted on the SNF PPS website (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html*), in the paragraph entitled ''Case Mix Adjustment.''

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

B. Consolidated Billing

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

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

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

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

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

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

In the FY 2001 SNF PPS proposed rule, we specifically solicited public comments identifying HCPCS codes in

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

We also stated in the FY 2001 SNF PPS proposed rule that the original BBRA amendment and the CAA, 2021 identified a set of excluded items and services by means of specifying individual HCPCS codes within the designated categories that were in effect as of a particular date (in the case of the BBRA 1999, July 1, 1999, and in the case of the CAA, 2021, July 1, 2020), as subsequently modified by the Secretary. In addition, as stated in the FY 2001 SNF PPS proposed rule, the statute (sections 1888(e)(2)(A)(iii)(II) through (VI) of the Act) gives the Secretary authority to identify additional items and services for exclusion within the five specified categories of items and services described in the statute, which are also designated by HCPCS code. Designating the excluded services in this manner makes it possible for us to utilize program issuances as the vehicle for accomplishing routine updates to the excluded codes to reflect any minor revisions that might subsequently occur in the coding system itself, such as the assignment of a different code number to a service already designated as excluded, or the creation of a new code for a type of service that falls within one of the established exclusion categories and meets our criteria for exclusion.

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

The following is a summary of the public comments received on the consolidated billing, along with our responses.

Comment: Commenters submitted two specific HCPCS codes representing services that the commenters suggested would qualify for exclusion from SNF CB. One commenter requested that CMS exclude Vyvgart Hytrulo (HCPCS code J9334), which was approved in 2023 for the treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive, as well as for adult patients with chronic inflammatory demyelinating polyneuropathy (CIDP). The commenter did not specify which of the five exclusion categories under which this service could be excluded but cited that it meets the criteria as a high-cost, low-probability event in a SNF. Another commenter requested that CMS exclude Imdelltra (HCPCS code J9026, a new anticancer drug approved in 2024) in the chemotherapy category. The commenter stated that the drug is a high-cost, low-probability anti-cancer treatment, and represents a new technology or change in medical practice within the statutory chemotherapy category. The commenter also stated that CMS has previously excluded codes the commenter believes are similar to the requested new exclusion.

Response: With regard to Vyvgart Hytrulo, this product is used to treat myasthenia gravis, not cancer, and does not fall into any statutory drug categories for consolidated billing (CB) exclusion. The ''high-cost, low-probability'' criterion is necessary, but insufficient, in and of itself, to qualify a service for exclusion; the service must also fit one of the five service categories as previously described in this section of the preamble. Accordingly, we are not excluding Vyvgart Hytrulo from SNF consolidated billing.

Imdelltra is a targeted immunotherapy anticancer drug, approved for treatment by infusion of extensive stage small cell lung cancer. It represents a newer form of cancer treatment than traditional chemotherapy, as it targets antigens on the cancer cells and simultaneously engages a patient's own ''T ''cells via another antigen, activating the immune system to destroy the cancer cells. As previously stated in prior rulemaking cycles, most recently in the FY 2025 SNF PPS final rule (89 FR 64048), ''chemotherapy is a specific subset of cancer treatment characterized by its systemic attacking of cell growth.'' We further stated in the FY 2024 SNF PPS final rule (88 FR 53200) that services that ''. . . are not actually chemotherapy drugs, but rather either immunotherapy or other non-chemotherapy treatments for cancer, or non-chemotherapy services related to or used in conjunction with chemotherapy or in treatment of chemotherapy symptoms . . . do not fit the chemotherapy category or any existing exclusion categories.'' Accordingly, we are not excluding Imdelltra, from SNF consolidated billing.

Comment: Commenters submitted several comments that are beyond the agency's statutory authority and/or have already been addressed in previous rulemaking cycles. One comment reiterated a previous recommendation that CMS develop a policy to exclude high-cost items/services from consolidated billing. Another commenter reiterated a previous recommendation that CMS exclude Tumor Treating Fields (''TTFields'') therapy, but this is not chemotherapy and does not fit existing categories. Another commenter submitted a list of medications that they acknowledged were outside the five service categories in which CMS has statutory authority to add exclusions, but requested CMS to consider for future exclusion, including: costs of treatment for residents with multiple sclerosis (MS); GLP–1 medications; migraine medications; Aimovig, Ajovy, Emgality, Vyepti, Reyvow, Ubrelvy, and Nurtec; and continuous glucose monitoring devices.

Response: As previously specified in this section of the preamble, the authority afforded to us under the law to modify the list of services excluded from SNF consolidated billing is limited to adding or removing HCPCS codes representing high-cost low-probability services from the five specific service categories identified in the statute. Any of the modifications to consolidated billing and/or the SNF program suggested by the previously mentioned comments would require an act of Congress to modify the law.

Comment: A commenter requested that CMS consider applying consolidated billing rules to oral chemotherapy when administered in the SNF setting.

Response: Consolidated billing rules apply to oral chemotherapy, and oral chemotherapy may be excluded from consolidated billing rules in certain scenarios. The drug must otherwise meet the ''high-cost, low probability'' standard. Furthermore, coverage must be available under the Medicare Part B oral chemotherapy drug benefit. As stated in the FY 2019 SNF PPS final (83 FR 39181, August 8, 2018), while Medicare Part B does provide some

limited coverage for certain oral chemotherapy drugs under section 1861(s)(2)(Q) of the Act, that coverage ''. . . is restricted to those with the same indication and active ingredient(s) as a covered non-oral anti-cancer drug.'' On the other hand, we stated in the FY SNF 2020 PPS final rule (84 FR 38744) that the law does not provide a basis for excluding Medicare Part-D-only chemotherapy drugs, as the statutory CB exclusion mechanism described at subclause (II) of § 1888(e)(2)(A)(i) of the Act solely encompasses those services for which payment otherwise ''may be made under Part B.''

Comment: Commenters expressed general appreciation for CMS soliciting public comments to identify HCPCS codes that meet the criteria for exclusion from consolidated billing within the five specific service categories identified in the statute. Commenters stated that they have heard of residents being denied admission or having care restricted due to expensive chemotherapy and other services. One commenter stated that chemotherapy services pose a financial barrier for rural SNFs due to their high cost and administrative complexity. Another commenter added that services in the five specified categories are very costly and restrict access to SNF care. Commenters stated they would continue to try to identify HCPCS codes that meet the requirements for exclusion.

Response: We thank commenters for their review and support.

C. Payment for SNF-Level Swing-Bed Services

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

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

V. Other SNF PPS Issues

Technical Updates to the PDPM ICD–10 Mappings

1. Background

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

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

On the other hand, substantive changes that go beyond the intention of maintaining consistency with the most current PDPM ICD–10 code mappings, such as changes to the assignment of a code to a clinical category or comorbidity list, are made via notice and comment rulemaking, because they are changes that affect policy. We stated in the proposed rule that in the case of any diagnoses that are either currently mapped to ''Return to Provider'' clinical category or that we proposed to classify into this category, this is not intended to reflect any judgment on the importance of recognizing and treating these conditions. Rather, we believe that there are more specific or appropriate diagnoses that would better serve as the primary diagnosis for a Medicare Part-A covered SNF stay.

2. Clinical Category Changes for New ICD–10 Codes for FY 2026

Each year, we review the clinical categories assigned to new ICD–10 diagnosis codes and propose adding, removing, or changing the assignment to another clinical category if warranted. We proposed to change the clinical category assignment for the following 34 new ICD–10 codes that were effective October 1, 2024. We proposed that 33 ICD–10 codes would be changed to ''Return to Provider,'' and 1 ICD–10 code would be changed from the ''Acute Neurologic'' category to the ''Medical Management'' category.

a. Type 1 Diabetes Mellitus

Type 1 diabetes mellitus is an autoimmune condition characterized by insulin deficiency, leading to chronic hyperglycemia. Codes E10.A0 (*Type 1 diabetes mellitus, presymptomatic, unspecified*), E10.A1 (*Type 1 diabetes mellitus, presymptomatic, Stage 1*), E10.A2 (*Type 1 diabetes mellitus, presymptomatic, Stage 2*), and E10.9 (*Type 1 diabetes mellitus without complications*) were initially assigned to the ''Medical Management'' clinical category. However, these codes refer to diagnoses in which a patient's Type 1 diabetes is considered presymptomatic, which means a patient has not developed symptoms, or a patient that is not experiencing any complications associated with having diabetes. In both cases, given the patient has not exhibited symptoms or experienced complications from the condition,

testing and treatments for these diagnoses would typically occur on an outpatient basis and not require an inpatient SNF stay in and of themselves. Therefore, we do not believe these codes will serve appropriately as the primary diagnoses for a Medicare Part A-covered SNF stay. We are requiring claims reporting of primary diagnoses that are the reason for SNF admission, to enable their mapping to clinical categories that reflect the most accurate resource use for payment. This does not preclude inclusion of type I diabetes mellitus diagnoses or any related clinical needs in the beneficiary's plan of care. As a result, we are changing the mapping of these codes from ''Medical Management'' to the clinical category of ''Return to Provider''.

b. Hypoglycemia

Hypoglycemia, defined as blood glucose levels below 70 mg/dL, is a common complication in individuals with diabetes mellitus or other metabolic disorders. Codes E16.A1 (*Hypoglycemia level 1*), E16.A2 (*Hypoglycemia level 2*), E16.A3 (*Hypoglycemia level 3*), E16.0 (*Drug-induced hypoglycemia without coma*), E16.1 (*Other hypoglycemia*), E16.2 (*Hypoglycemia, unspecified*), E16.3 (*Increased secretion of glucagon*), E16.4 (*Increased secretion of gastrin*), E16.8 (*Other specified disorders of pancreatic internal secretion*), and E16.9 (*Disorder of pancreatic internal secretion, unspecified*) were initially assigned to the ''Medical Management'' clinical category. These diagnoses are typically treated using interventions such as, but not limited to, blood sugar monitoring education, dietary counseling, physical exercise education and training, and pharmacological interventions. Given these interventions, treatment for these diagnoses would typically occur on an outpatient basis and not require an inpatient SNF stay in and of themselves. Therefore, we do not believe these codes will serve appropriately as the primary diagnoses for a Medicare Part A-covered SNF stay. We are requiring claims reporting of primary diagnoses that are the reason for SNF admission, to enable their mapping to clinical categories that reflect the most accurate resource use for payment. This does not preclude inclusion of a hypoglycemia diagnoses or any related clinical needs in the beneficiary's plan of care. As a result, we are changing the mapping of these codes from ''Medical Management'' to the clinical category of ''Return to Provider''.

c. Obesity

Obesity is a chronic, relapsing, multifactorial disease characterized by excessive adipose tissue accumulation that increases the risk of metabolic, cardiovascular, and musculoskeletal disorders. Codes E66.811 (*Obesity, class 1*), E66.812 (*Obesity, class 2*), E66.89 (*Other obesity not elsewhere classified*), E66.01 (*Morbid (severe) obesity due to excess calories*), E66.09 (*Other obesity due to excess calories*), E66.1 (*Drug-induced obesity*), E66.3 (*Overweight*), and E66.9 (*Obesity, unspecified*) were initially assigned to the ''Medical Management'' clinical category. However, these diagnoses are typically treated using interventions such as, but not limited to, lifestyle interventions, psychosocial therapy and support, weight management programs, and pharmacological interventions. Given these interventions, treatment for these diagnoses would typically occur on an outpatient basis and not require an inpatient SNF stay in and of themselves. Therefore, we do not believe these codes will serve appropriately as the primary diagnoses for a Medicare Part A-covered SNF stay. As a result, we are changing the mapping of these codes from ''Medical Management'' to the clinical category of ''Return to Provider''.

d. Anorexia Nervosa, Restricting Type

Anorexia Nervosa (AN) is a psychiatric disorder characterized by severe food restriction, intense fear of weight gain, and distorted body image. Patients with AN, restricting type may present with significant weight loss, malnutrition, and/or medical complications such as bradycardia, osteoporosis, electrolyte imbalances, and/or organ dysfunction. Code F50.010 (*Anorexia nervosa, restricting type, mild*) was initially assigned to the ''Medical Management'' clinical category. However, this diagnosis is typically treated using interventions such as, but not limited to, psychosocial therapy and support, nutritional counseling, and pharmacological interventions. Given these interventions, treatment for this diagnosis would typically occur on an outpatient basis and not require an inpatient SNF stay in and of itself. Therefore, we do not believe this code will serve appropriately as the primary diagnosis for a Medicare Part A-covered SNF stay. As a result, we are changing the mapping of this code from ''Medical Management'' to the clinical category of ''Return to Provider''.

e. Anorexia Nervosa, Binge Eating/Purging Type

AN is a psychiatric disorder characterized by severe food restriction, intense fear of weight gain, and distorted body image. Individuals with AN binge eating/purging type engage in recurrent binge eating and/or purging behaviors. Codes F50.020 (*Anorexia nervosa, binge eating/purging type, mild*) and F50.021 (*Anorexia nervosa, binge eating/purging type, moderate*) were initially assigned to the ''Medical Management'' clinical category. However, these diagnoses are typically treated using interventions such as, but not limited to, psychosocial therapy and support, nutritional counseling, and pharmacological interventions. Given these interventions, treatment for these diagnoses would typically occur on an outpatient basis and not require an inpatient SNF stay in and of themselves. Therefore, we do not believe these codes will serve appropriately as the primary diagnoses for a Medicare Part A-covered SNF stay. As a result, we are changing the mapping of these codes from ''Medical Management'' to the clinical category of ''Return to Provider''.

f. Bulimia Nervosa

Bulimia nervosa is an eating disorder characterized by recurrent episodes of binge eating, consuming large amounts of food within a short period, followed by self-induced vomiting, laxative misuse, fasting, or excessive exercise. Codes F50.21 (*Bulimia nervosa, mild*) and F50.22 (*Bulimia nervosa, moderate*) were initially assigned to the ''Medical Management'' clinical category. However, these diagnoses are typically treated using interventions such as, but not limited to, Cognitive-Behavioral Therapy (CBT), psychotherapy, nutritional counseling, and pharmacological interventions. Given these interventions, treatment for these diagnoses would typically occur on an outpatient basis and not require an inpatient SNF stay in and of themselves. Therefore, we do not believe these codes will serve appropriately as the primary diagnoses for a Medicare Part A-covered SNF stay. As a result, we are changing the mapping of these codes from ''Medical Management'' to the clinical category of ''Return to Provider''.

g. Binge Eating Disorder

Binge eating disorder is characterized by recurrent episodes of binge eating without compensatory behaviors such as purging, fasting, and excessive exercise. Codes F50.810 (*Binge eating disorder, mild*) and F50.81(*Binge eating disorder, moderate*) were initially

assigned to the ''Medical Management'' clinical category. However, these diagnoses are typically treated using interventions such as, but not limited to, CBT, psychotherapy, nutritional counseling, and pharmacological interventions. Given these interventions, treatment for these diagnoses would typically occur on an outpatient basis and not require an inpatient SNF stay in and of themselves. Therefore, we do not believe these codes will serve appropriately as the primary diagnoses for a Medicare Part A-covered SNF stay. As a result, we are changing the mapping of these codes from ''Medical Management'' to the clinical category of ''Return to Provider''.

h. Pica and Rumination Disorder

Pica is an eating disorder characterized by the persistent consumption of non-nutritive, non-food substances for at least one month. Rumination is an eating disorder where individuals repeatedly regurgitate food, rechew, re-swallow, or spit out, for at least one month. Codes F50.83 (*Pica in adults*), F50.84 (*Rumination disorder in adults*), F98.21 (*Rumination disorder of infancy and childhood*), and F98.3 (*Pica of infancy and childhood*) were initially assigned to the ''Medical Management'' clinical category. However, these diagnoses are typically treated using interventions such as, but not limited to, behavioral therapy, nutritional counseling, environmental modifications, and pharmacological interventions. Given these interventions, treatment for these diagnoses would typically occur on an outpatient basis and not require an inpatient SNF stay in and of themselves. Therefore, we do not believe these codes will serve appropriately as the primary diagnoses for a Medicare Part A-covered SNF stay. As a result, we are changing the mapping of these codes from ''Medical Management'' to the clinical category of ''Return to Provider''.

i. Serotonin Syndrome

Serotonin syndrome is a potentially life-threatening condition caused by excess serotonin in the central nervous system, typically resulting from drug interactions or overdose of serotonergic medications. Code G90.81 (*Serotonin syndrome*) was initially assigned to the ''Acute Neurologic'' clinical category. However, this diagnosis requires specific interventions including identifying and discontinuing causative agents, symptom management and support, pharmacological management, patient education, and potentially emergency care or ICU admission depending on severity. Given these treatment requirements, care for this diagnosis typically occurs on an outpatient basis or in an acute care hospital setting rather than requiring an inpatient Part A SNF stay. Therefore, this code does not serve appropriately as the primary diagnosis for a Medicare Part A-covered SNF stay while assigned to the ''Acute Neurologic'' clinical category. Consequently, we propose remapping this code from ''Acute Neurologic'' to the ''Medical Management'' clinical category.

We solicited comments on the proposed changes to the PDPM ICD–10 mappings discussed earlier in this section. We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported the proposed reclassification of the PDPM mappings changes for type 1 diabetes mellitus, hypoglycemia, obesity, anorexia nervosa-restricting type, anorexia nervosa-binge eating/purging type, bulimia nervosa, binge eating disorder, pica and rumination disorder, and serotonin syndrome. These commenters agreed these mapping changes would improve billing accuracy, promote more appropriate diagnoses for Part A skilled nursing facility (SNF) stays, and ultimately improve patient care.

Response: We appreciate the support for these proposed ICD–10 mapping changes.

Comment: A few commenters expressed concerns with the proposed reclassification of certain conditions from a given clinical category to a Return to Provider status, suggesting changing the clinical categories could potentially lead to increased claims denials and corrections, increased administrative burdens, delays in care, or restrictions in patient access to skilled care by remapping codes from the Medical Management clinical category to Return to Provider.

Response: We appreciate the comments and concerns raised by the commenters. As part of our ongoing review and refinement of the PDPM ICD–10 mappings, including clinical review, we determined that these diagnoses would not serve as the basis for a Part A admission to a SNF. Treatment for these diagnoses would not require, in and of themselves, an inpatient Medicare Part A SNF stay. Therefore, we do not believe these codes would serve appropriately as primary diagnoses for a Medicare Part A-covered SNF stay. We require claims reporting of primary diagnoses that are the reason for SNF admission, to enable their mapping to clinical categories that reflect the most accurate resource use for payment. This does not preclude inclusion of other, co-occurring diagnoses and any related clinical needs in the beneficiary's plan of care.

We believe that remapping the codes in question from the Medical Management clinical category to Return to Provider will also help reduce billing and administrative burdens by preventing unnecessary claim denials. Specifically, improving billing accuracy with correct primary diagnosis codes reduces administrative burden by preventing claim rejections that require time-intensive corrections and resubmissions. In the event a patient is admitted with codes mapped to Return to Provider, these codes may still be used as secondary diagnoses when appropriate.

Comment: One commenter stated CMS should reconsider mapping ICD–10 code M62.81, Muscle Weakness (Generalized) from Return to Provider to an alternative category and be used as a primary diagnosis.

Response: We considered this request and, as stated in the FY 2023 SNF PPS final rule (87 FR 47524), we continue to believe that M62.81 Muscle Weakness (Generalized) is nonspecific. If the original condition has resolved but the resulting muscle weakness persists due to the known original diagnosis, more specific codes exist that would better account for the ongoing muscle weakness. Many musculoskeletal conditions result from previous injury or trauma to a site or are recurrent conditions. This symptom, without specification of etiology or severity, does not justify being designated as a primary diagnosis for a Medicare Part A skilled stay in a SNF. Patients with Muscle Weakness (Generalized) may obtain a more specific diagnosis that identifies the cause of the generalized muscle weakness. The specific diagnosis may then be used to develop an appropriate care plan for the patient.

Comment: A couple of commenters recommended code G90.81 (Serotonin Syndrome) remain mapped to the Acute Neurologic clinical category instead of being remapped to Medical Management.

Response: We appreciate the comments and concerns raised regarding our proposal to remap code G90.81 (Serotonin syndrome) from the Acute Neurologic clinical category to the Medical Management clinical category. We acknowledge that commenters have noted the variable severity of serotonin syndrome and the potential need for intensive monitoring and medication management. While we recognize that serotonin syndrome can

present with varying degrees of severity, our proposal to remap this code to Medical Management is based on several key considerations.

The primary interventions for serotonin syndrome, including identification and discontinuation of causative agents, symptom management, and pharmacological interventions, are typically managed in outpatient settings or acute care hospitals rather than requiring SNF care under a Medicare Part A stay. The condition's management focuses on medication adjustments and monitoring rather than the intensive neurological rehabilitation or skilled nursing services that characterize appropriate Medicare Part A SNF admissions for conditions classified under the Acute Neurologic clinical category.

For Medicare Part A SNF coverage, the primary diagnosis should reflect conditions that necessitate skilled nursing care or rehabilitation services for a Part A SNF admission. While serotonin syndrome may require careful monitoring, it does not inherently require the skilled nursing interventions that justify a Medicare Part A SNF admission as a primary diagnosis when classified within the Acute Neurologic category versus the proposed Medical Management clinical category.

It is important to note that remapping this code to Medical Management does not eliminate access to SNF care when medically necessary. Patients with serotonin syndrome may still receive appropriate treatment in the most suitable care setting, have G90.81 used as either a primary or secondary diagnosis when relevant to their overall care plan, and access Medicare Part A SNF services when their primary condition requires skilled nursing care.

This remapping will improve the accuracy of primary diagnosis coding for Medicare Part A SNF stays, reducing administrative burdens while ensuring that patients receive care in the most appropriate setting for their specific needs.

Comment: One commenter reported concerns that remapping eating disorder codes to the clinical category of Return to Provider would create gaps in care and contrast with the ''Make America Healthy Again'' initiative. At the same time, the commenter acknowledged eating disorders can co-occur with other needs requiring skilled care.

Response: We appreciate the thoughtful comments regarding our proposal to remap the codes for Anorexia Nervosa, Restricting Type; Anorexia Nervosa, Binge Eating/Purging Type, Bulimia Nervosa, Binge Eating Disorder, and Pica and Rumination Disorder, from Medical Management to Return to Provider. We understand the commenter's concerns about potential care gaps and alignment with health initiatives, and we value their acknowledgment that eating disorders may co-occur with other conditions requiring skilled care, however they would not formulate the basis for needing SNF admission. The primary interventions for eating disorders as primary diagnoses, including behavioral therapy, nutritional counseling, environmental modifications, and pharmacological interventions, are most effectively delivered in specialized outpatient settings or dedicated eating disorder treatment facilities. These interventions do not typically require the skilled nursing services that characterize appropriate Medicare Part A SNF admissions. By remapping these codes to Return to Provider, patients can receive care in the most clinically appropriate and therapeutically effective environment. Requiring claims reporting of primary diagnoses that are the reason for SNF admission enables their mapping to clinical categories that reflect the most accurate resource use and does not preclude their inclusion in beneficiaries' plan of care. These eating disorder codes may continue to be used as secondary diagnoses when clinically relevant and medically necessary.

Comment: We received comments recommending out-of-scope mapping changes for various diagnoses, including sepsis, oral and laryngeal cancers, secondary cancers, orthopedic surgeries and conditions, brain tumor, hepatic encephalopathy, and speech-language pathology (SLP) comorbidities.

Response: We appreciate the thoughtful comments and recommendations submitted regarding potential mapping changes for various diagnoses, including sepsis, oral and laryngeal cancers, secondary cancers, orthopedic surgeries and conditions, brain tumor, hepatic encephalopathy, and SLP comorbidities. While these recommended changes fall outside the scope of the current rulemaking cycle, we recognize their potential significance for improving the accuracy and clinical appropriateness of our coding system. To the extent that these changes represent substantive modifications to the ICD–10 code mappings, we will carefully consider these comments for future rulemaking processes.

After considering the public comments, we are finalizing our proposed changes to the clinical category assignments for these 34 new ICD–10 codes.

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

A. Background and Statutory Authority

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

In section VI.C. of the proposed rule, we proposed to remove four items previously adopted as standardized patient assessment data elements under the social determinants of health (SDOH) category beginning with the FY 2027 SNF QRP: one item for Living Situation, two items for Food, and one item for Utilities. In section VI.D. of the proposed rule, we proposed to amend our reconsideration policy and process. We also solicited public comments on several Requests for Information (RFIs), specifically on: (1) future measure concepts for the SNF QRP; (2) potential revisions to the data submission deadlines for assessment data collected for the SNF QRP; and (3) advancing digital quality measurement in SNFs.

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

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

1. Quality Measures Currently Adopted for the FY 2028 SNF QRP

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

For a discussion of the factors we use to evaluate whether a measure must be removed from the SNF QRP, we refer readers to our regulations at § 413.360(b)(2) and to the FY 2019 SNF PPS final rule (83 FR 39267 through 39269). We did not propose to remove any measures from the SNF QRP.

TABLE 12: Quality Measures Currently Adopted for the FY 2028 SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post Acute Care (PAC)
TOH-Patient	Transfer of Health (TOH) Information to the Patient Post Acute Care (PAC)
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
National Healthcare Safety Network	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

C. Removal of Four Standardized Patient Assessment Data Elements Beginning With the FY 2027 SNF QRP

We refer readers to the FY 2025 SNF PPS final rule (89 FR 64100 through 64111) where we finalized the adoption of four new items as standardized patient assessment data elements under the SDOH category for addition to the Minimum Data Set (MDS).[3] Specifically, we finalized the following items to be added to the MDS in the FY 2025 SNF PPS final rule: one item for Living Situation (R0310); two items for Food (R0320A and R0320B); and one item for Utilities (R0330). As finalized in the FY 2025 SNF PPS final rule, SNFs would be required to report these data elements using the MDS beginning with residents admitted on October 1, 2025, through December 31, 2025, for purposes of the FY 2027 SNF QRP and each program year after (89 FR 64115 through 64118).

In the proposed rule, we proposed to remove these four standardized patient assessment data elements under the SDOH category from the MDS as we acknowledge the burden associated with these items at this time. We continuously look for ways to balance the need for data collections regarding quality care and the burden that such data collections may have on SNFs and their staff. One goal we have is to facilitate improved health care delivery by requiring different systems and software applications to communicate and exchange data. Therefore, we would like to work towards the workflow for these items being part of a low burden interoperable electronic system. The focus will turn towards how the data and associated recommendations can improve care coordination, efficiency, reduction in errors, and resident experience. As health information technology (IT) advances and interoperability of data becomes more standardized, the burden to collect and share clinical data on these and other relevant resident information will become less burdensome, allowing for better outcomes for SNF residents and their families. The objectives of the SNF QRP continue to be the improvement of care, quality, and health outcomes for all residents through transparency and quality measurement, while not imposing undue burden on essential health providers.

We proposed that SNFs would not be required to collect and submit the Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330) items using the MDS beginning with residents admitted on or after October 1, 2025, removing the required collection and reporting of these items that we previously finalized. We also proposed

[3] The MDS 3.0 is CMS's required assessment instrument used by SNFs to collect certain data from residents upon their admission and discharge from the SNF. *See* section 1899B of the Act, which requires SNFs to use of Post-Acute Care (PAC) assessment instruments for collecting and submitting to CMS certain standardized patient assessment data as part of PAC quality reporting programs, including the SNF QRP.

that collecting these items would not be required to meet the SNF QRP requirements to avoid a 2 percent payment reduction beginning with the FY 2027 SNF QRP.

In the proposed rule, we calculated that removing these items from the data collection for the FY 2027 SNF QRP would keep the 15,253 SNFs from incurring 31,791.20 hours of administrative burden at a cost of $2,228,563.12 (or $146.11 per SNF) at this time (90 FR 18605). We refer readers to section IX.A.6.a. of this final rule for details on this estimated burden reduction.

The following is a summary of the public comments received on our proposal to remove these four standardized patient assessment data elements collected under the SDOH category from the SNF QRP beginning with the FY 2027 SNF QRP, along with our responses.

Comment: Several commenters supported the proposed removal of the four SDOH assessment items, stating that they would add complexity and administrative burden to the resident assessment process. One commenter stated that this proposed removal would be most beneficial for rural SNFs, who may lack dedicated administrative personnel to manage new data collection mandates. Many of these commenters expressed concerns that these items can be time-consuming to collect and detract from direct resident care. A few commenters acknowledged that CMS must work towards a balance of SNF provider burden and data collection efforts for quality, ensuring data adds value to its program and advances health care.

Several commenters that supported the proposed removal stated that, while the SDOH items are an important part of discharge planning, the SDOH items were not relevant to the SNF QRP. Two other commenters stated the information would already be in the resident's medical record and would thus be duplicative of collection efforts across the care continuum, such as data collected by the hospital. A few commenters noted that, while the data elements may impact a resident's overall well-being, the SDOH items are reflective of issues outside the SNF and will not be resolved during the stay. Some commenters stated that these items do not accurately reflect the facility's outcomes, and that SDOH screening is better addressed through community-based care settings or discharge planning rather than SNF quality reporting.

Response: We thank commenters for their support for our proposal to remove these four SDOH items from the standardized patient assessment data elements collected and submitted using the MDS. We continue to monitor the SNF QRP data collection requirements to look for ways to reduce administrative burden, where appropriate, while maintaining a high standard of quality care. We agree that removing these items at this time will alleviate some of the burden on SNF providers associated with SNF QRP data collection and submission requirements. We intend to align the SNF QRP more closely with our overarching goal for improved health care delivery through health IT advances and low-burden interoperable electronic systems. As we stated in the FY 2026 SNF PPS proposed rule (90 FR 18605), we plan to refocus efforts on how data elements can improve care coordination, efficiency, reduction in errors, and resident experience.

We appreciate commenters' recognition of having an appropriate balance of burden and value in quality measurement programs, such as the SNF QRP. By streamlining the number of data elements required for reporting, SNFs and their staff can focus efforts and resources to address the quality issues that matter most to their residents. As stated in section VI.E. of this rule, we are soliciting comment on measurement concepts that address residents' well-being while more appropriately reflecting factors that are within practitioners' and facilities' scope of care or where practitioners can provide actionable advice that will help reduce the prevalence of chronic diseases, including nutrition, increased adherence to expected daily thresholds for physical activity, minimization of chronic stressors, and improvements in mental health.

We also acknowledge that many SNFs already collect the information that would otherwise be required under these four SDOH items as part of the discharge planning process. We note that SNFs may continue collecting information that is beneficial regardless of the requirements of the SNF QRP, particularly if it may facilitate discharge planning and contribute to quality improvement efforts.

Comment: One commenter suggested making the four SDOH measures optional in the SNF QRP.

Response: We wish to clarify that we did not adopt SDOH measures. In the FY 2025 SNF PPS final rule (89 FR 64100 through 64111), we finalized the adoption of four new standardized patient assessment data elements under the SDOH category for inclusion in the SNF QRP. As previously finalized, SNFs would have collected and submitted these standardized patient assessment data using the MDS beginning with residents admitted on or after October 1, 2025, in accordance with sections 1888(e)(6)(B)(i)(III) and 1899B(a)(1)(A)(i) and (b)(1) of the Act. In the FY 2025 SNF PPS final rule (89 FR 64100), we described these statutory requirements regarding the collection and submission of standardized patient assessment data under the SNF QRP. While SNFs collect and submit standardized patient assessment data using the MDS to fulfill SNF QRP requirements at section 1888(e)(6)(B)(i)(III) of the Act, and these data may be used to calculate SNF QRP measures as provided in section 1889B(b)(1)(B) of the Act, these data are not in themselves quality, resource use, and other measures specified for the SNF QRP.

In the proposed rule (90 FR 18605 and 18606), we proposed the removal of these four standardized patient assessment data elements from the SNF QRP. We did not propose to modify these four SDOH items to be optional data elements on the MDS that SNFs could voluntarily report. Because we are finalizing our proposal to remove these four SDOH items as proposed, they will not be added to the MDS item set for voluntary data collection efforts. If SNFs want to voluntarily collect them, they can do so.

Comment: We received many comments that were opposed to our proposal to remove the four SDOH items from the SNF QRP and recommended that CMS reconsider the proposal. These commenters stated that this information adds value to SNFs, citing certain literature on how screening for SDOH improves health outcomes and how this information facilitates discharge planning and coordination of care across settings providing a proactive approach to risks. Many of these commenters stated that collecting these data allows SNFs to identify barriers to care access and adherence to medical plans. Some commenters further stated that they are already collecting SDOH data on their residents to support efforts of nurses, social workers, and care managers. One of these commenters stated that these items are particularly useful in rural SNFs to address deficits in rural residents' living situations. A few commenters stated these SDOH items were particularly important in caring for patients with complex or chronic conditions and geriatric patients. These commenters noted that integration of SDOH into care planning can result in cost savings by reducing readmissions and emergency

department visits while improving patients' post-care outcomes.

Response: We appreciate the commenters' concerns and feedback regarding the importance of collecting these SDOH items from SNF residents and acknowledge the value that commenters ascribe to the collection of this information for discharge planning and care coordination. We recognize commenters' experiences using SDOH data to improve outcomes and facilitate high quality care through improved coordination between SNF providers. We also acknowledge feedback from commenters that healthcare outcomes may be different for those residents experiencing unstable housing, food insecurity, or challenges paying utilities.

However, in reviewing the data collection and reporting requirements for the FY 2027 SNF QRP, we determined that these SDOH items should be removed from the MDS prior to the start of data collection and submission. We have re-evaluated the value of adding these SDOH items to the MDS for the purposes of the SNF QRP against their burden at this time. We considered that SNFs have not yet begun to report these data, we do not currently have a use for these items in the SNF QRP, and these SDOH items are not clinical items related to direct resident care. We also have refocused our efforts on modernization of health care and health care systems, which may support less burdensome ways of collecting SDOH data in the future. We continuously review and reassess the balance of data collection and SNF provider burden for the SNF QRP, and at this time, determined these SDOH items should be removed prior to implementation.

The objectives of the SNF QRP continue to be the improvement of care, quality, and health outcomes for all patients through transparency and quality measurement, while balancing burden for SNFs and their staff. As outlined in our request for information in the FY 2026 SNF PPS proposed rule (90 FR 18608 and 18609), we are refocusing our efforts to advance the digital quality measurement transition to include ways for data elements, such as those related to SDOH, to be collected as part of a low-burden interoperable electronic system. Given these administrative goals and efforts to reduce burden for SNFs, we do not believe that the collection of SDOH items via the MDS assessment outweighs the cost and burden of collecting them at this time.

At this time, we believe that halting the implementation of the four SDOH items prior to their being added to the MDS on October 1, 2025 removes the burden these data collection and submission requirements would impose on SNFs before most training activities, data collection, reviews of the guidance manuals, and other implementation tasks have occurred. To the extent SNFs may find collecting this or similar information from their residents helpful to inform clinical decisions and discharge planning, the removal of collecting and reporting this information to CMS to comply with SNF QRP requirements should not, in any way, preclude SNFs from collecting and using this information on their own.

Comment: One commenter stated that residents are often sent to SNFs when they are unable to live at home for reasons related to the four SDOH items. The commenter stated that retaining the SDOH items in the MDS would help mitigate a gap in resources that limit SNFs from effectively addressing SDOH issues (for example, staffing inadequacies, managed care and commercial insurance restrictions, and insufficient reimbursement rates). The commenter stated that these items would help local and Federal agencies better understand where funds are allocated and how they are utilized.

Response: We acknowledge that some SNF residents may face challenges related to SDOH that affect the resident being safely discharged home. We wish to clarify that SNFs have not collected these four items for the purposes of the SNF QRP to date because data collection and submission using the MDS was set to begin with residents admitted on or after October 1, 2025. Additionally, we interpret the comment regarding resource gaps to say that these SDOH items could be utilized by local and Federal agencies to illuminate limits placed on SNFs by managed care and commercial insurance companies or to highlight areas for staffing improvements. We do not believe that the submission of these items to us would achieve these goals, and we wish to clarify that the SDOH items were never intended for the purpose of informing us about staffing challenges or private payers' insurance practices or reimbursement rates. The purpose of the SNF QRP is to require collection and submission of data to CMS as we have specified. Even though we will no longer require that SNFs collect and submit these four items to CMS using the MDS, SNFs can still collect and use SDOH information and share this with local agencies, in compliance with applicable laws governing confidentiality and privacy of patient/resident information, if they believe this would be beneficial.

Comment: Another commenter specifically opposed removing the Utilities (R0330) item on the MDS from the SNF QRP. This commenter stated that the availability of reliable electricity is necessary for patients who need mechanical devices, such as ventilators, CPAP machines, and oxygen equipment, after discharge. This commenter noted that a patient without access to electricity could not be safely discharged to home.

Response: We agree with the commenter about the importance of reliable electricity being available for residents who need mechanical devices, such as ventilators, CPAP machines, and oxygen equipment, after discharge. We disagree, however, that if the Utilities (R0330) item is removed from the MDS item set, then SNFs would not question the resident about and consider this information in their discharge plan. SNFs are already required by our regulation at § 483.21(c)(1) to develop and implement an effective discharge planning process, including ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident (§ 483.21(c)(1)(i)). On this basis, we believe that if it were necessary for residents to have electricity to use mechanical devices after discharge from the SNF, then the SNF would be required to address and consider such need as part of their planning process for safely discharging a resident to home.

Comment: One commenter recommended that, rather than removing these four SDOH items, CMS should invest in reducing the manual burden associated with collecting and submitting these items by using automation via interoperable systems (for example, electronic health record (EHR)-based application programming interfaces (APIs) as suggested by the Fast Healthcare Interoperability Resources® (FHIR®) Roadmap and Trusted Exchange Framework and Common Agreement™ (TEFCA™)). The commenter stated that the SDOH items support more equitable care coordination, and that facilitating the analysis and collection of data via more interoperable means is a critical step forward. One commenter disagreed that the burden of reporting outweighed the benefit of these items, stating that prospective losses in care efficiency and adverse outcomes may outweigh such minimal savings.

Response: We agree with the commenters that the exchangeability of information is important for a

comprehensive plan of care. We intend to work towards the workflow and data exchange for data elements being part of a less burdensome interoperable electronic system. We appreciate the commenters' suggestion to retain the items until a more efficient health IT infrastructure and data collection framework is in place. However, all data collection requirements have inherent burden associated with collection and we strive to balance that burden with the value of measuring the quality of care that residents receive. Data collection for these four SDOH items would be burdensome on SNFs and there is no current or planned use for the data in the SNF QRP at this time. As previously stated, SNFs can continue to collect this information to inform discharge planning but, for the purposes of the SNF QRP, we are finalizing our proposal to remove these four SDOH items from the MDS before implementation begins. This means that SNFs would not need to collect and submit this information to meet the requirements of the SNF QRP. With alleviation of this data collection requirement, SNFs could redistribute their resources toward efforts to improve or enhance clinical care, health IT, or other areas as determined by the SNF.

Comment: One commenter stated that CMS provided extensive support and rationale for adopting these four items in the FY 2025 SNF PPS final rule, developing a policy that was well-vetted and examined in detail. This commenter stated that CMS has not provided any reasoning or explanation in our proposal in the FY 2026 SNF PPS proposed rule as to why these are no longer important or how circumstances have changed to necessitate their removal. Other commenters stated that removal of these items prior to implementation is premature and that keeping them would support alignment of payment, data, and accountability mechanisms to improve care.

Response: In the proposed rule, we explained that the removal of these items is a result of our focus on balancing the need for data collection regarding quality care and the burden of these data collections on SNFs and their staff (90 FR 18605). We would like to reiterate that SNFs and their staff independently may determine to screen their residents for factors that may affect their clinical decision-making, even in the absence of a reporting requirement. We did not intend to suggest with our proposal to remove these items from SNF QRP requirements that SNFs should cease collecting this or similar information for other purposes, such as the SNF's resident-specific assessment of needs in developing a discharge plan as required by § 483.21(c)(1)(i). Rather, we are removing the four SDOH items from the MDS to reduce the burden of data collection and submission for the SNF QRP. Reducing the burden of SNF QRP requirements would enable SNFs and their staff to focus their efforts on clinical decision making by preserving clinicians' flexibility to address social risk factors in other ways that are tailored to the needs of and make the most sense for their resident populations.

We understand implementation efforts to collect and submit any data elements for the purposes of meeting SNF QRP requirements is inherently burdensome for SNFs and their staff, particularly adopting and implementing new data elements since they involve adjustments to health IT systems and EHRs, workflows, and staff trainings. We are always reviewing and reassessing this balance of data collection and SNF provider burden for the SNF QRP.

For the four SDOH items, we reconsidered the value of their collection and submission to us for the purposes of the SNF QRP against their burden at this time. We specifically considered that these items are not clinical in nature. While they reflect certain aspects of a resident's health that may inform clinical decisions, they are not factors within the scope of care a SNF and its staff provides. Furthermore, if maintained on the MDS, there is currently no use for these items in risk adjustment models, reporting of SNF measure results, or the development of new quality measures. We proposed removal of the four SDOH items from the MDS because SNFs have not started data collection for these items yet, we are not utilizing the information for any purpose at this time, and there is an agency-wide refocusing on modernization of health care and health care systems and on engaging SNFs and their staff with these health IT efforts. We are working towards developing less burdensome data collection methods as we believe leveraging technological advances and data modernizations can streamline standardization of the MDS in ways that support interoperable patient data and reduce time spent collecting this data by SNFs and their staff. We strive to collaborate with SNFs and their staff in these efforts as exhibited in our request for information on advancing digital quality measurement (dQM) in the FY 2026 SNF PPS proposed rule (90 FR 18608 and 18609). This collaboration includes reducing the burden of paperwork for participating in the SNF QRP, where possible, to support SNFs in moving towards health data technology and interoperability that promotes spending more time with residents. SNFs are welcome to continue collecting this information to inform care coordination and discharge planning.

Comment: A few commenters opposed our proposal to remove the SDOH items. They noted that these items are critical for risk adjustment and evaluating SNF performance across demographic groups.

Response: We wish to clarify that these four SDOH items are not currently being used for risk adjustment for any SNF QRP measures, and we do not currently utilize them for evaluating SNF performance across demographic groups. Furthermore, as we stated earlier, there are no current plans for utilizing the four SDOH items in risk adjustment models or to report SNF performance stratified by these elements, either publicly or in confidential feedback reports. While we finalized the adoption of the four SDOH items in the FY 2025 SNF PPS final rule (89 FR 64100 through 64111), SNFs have not begun to report these data. Because data collection has not begun and we do not have an active use for these items, we have re-evaluated the value of adding them to the MDS at this time.

Comment: A few commenters stated that the SDOH items provide important insights into housing, food, and utility insecurity, which affect patient outcomes and that removing these SDOH items is counter to national efforts aimed at improving health outcomes, including the agency's current goals related to the development of patient nutrition, physical activity, and well-being measures. The commenters noted that the SDOH items could be utilized to support the Make America Healthy Again initiative's core mission of a more efficient, prevention-focused health care system through the treatment of expensive complications that could be prevented through early identification of risks.

Response: We disagree but understand why SNF providers believe that removal of these items is counter to our national efforts aimed at improving health outcomes. In response to comments about the agency's goals related to nutrition and well-being, we do not believe these four SDOH items are the only foundational items needed for future measure development related to nutrition. As we finalized in the FY 2025 SNF PPS final rule (89 FR 64103), the two Food items (R0320A and R0320B) each assess one particular

aspect of nutrition: food availability and food security. These items do not encompass other relevant, meaningful information to improve residents' health outcomes, including healthy nutrition, sleep, and physical activity levels. In addition, we believe there are other existing items on the MDS that could support the development of measure concepts we are considering in the future. For example, the MDS includes nutrition items in Section K and Section I. To reiterate, at this time, we are removing these SDOH items to refocus efforts and resources towards a less burdensome interoperable system for SNFs participating in the SNF QRP and existing MDS items, such as the standardized patient assessment data elements in Section K that were finalized in the FY 2020 SNF PPS final rule (84 FR 38791 through 38795), provide a foundation for building out nutrition measures.

We are soliciting comment on ways to improve patient well-being across the Medicare programs and we remain committed to identifying the needs of residents and supporting SNFs in addressing those risks in a way that best accounts for residents' clinical circumstances with minimal burden. We also remain committed to supporting SNFs and their staff in addressing health risks and needs of at-risk populations such as those experiencing challenges with maintaining healthy nutrition and physical activity levels and managing or improving chronic stressors, mental health concerns, and chronic diseases.

Comment: A few commenters opposed to the removal of the four SDOH items from the SNF QRP were concerned that many healthcare facilities across the country have already made substantial investments to incorporate the screening of these SDOH items, including setting up systems, EHRs, and workflows. These commenters stated that this would amount to more than ongoing implementation costs, and that hospitals and other settings expecting to report these items have already expended the necessary resources to set up their systems and referral programs. These commenters stated that removing these measures does not negate their prior investments and may result in additional resources to rework their systems.

Similarly, a few commenters who supported the removal had concerns about the proposed effective date for removal, stating that there may be challenges for health IT companies to revise and deploy system updates to the MDS in time to meet potential compliance requirements, particularly if CMS does not finalize the proposal to remove. One of these commenters noted that this results in a significant risk of wasted resources, including design, coding, testing, and integration, that could be spent elsewhere to serve SNF providers and patients. These commenters encouraged CMS to consider mechanisms to provide earlier clarity in future rulemaking to prevent similar inefficiencies.

Response: We acknowledge the commenters' concerns and understand the time and resources that SNFs may have spent anticipating the requirement to collect these items as part of the SNF QRP. Since the inception and initial development of the SNF QRP, interested parties have requested we provide draft specifications for the upcoming release of the revised MDS as early as possible. We have been responsive to this request and aim to provide as much information as possible when that information is available. For our proposal to remove the four SDOH items, we posted two sets of draft MDS data specifications so SNFs and their staff could understand what would need to be done if the proposal was finalized. However, we would like to emphasize that the information released consists of draft MDS data specifications, not final specifications, and that the MDS data specifications cannot be finalized until CMS policies are finalized after the final rule is released.

We also note that the time and resources spent to build technical infrastructure accounts for only a portion of the overall cost we considered, which also includes training activities, continuous data collection, reviews of the guidance manuals, and other implementation tasks. Collecting these SDOH items is not a one-time task but an ongoing requirement for every SNF resident admitted to the facility. As a result, we believe removing these items before data collection begins will still save SNFs and their staff time, money, and resources.

After consideration of the public comments, we are finalizing our proposal to remove four standardized patient assessment data elements (one item for Living Situation (R0310); two items for Food (R0320A and R0320B); and one item for Utilities (R0330)) collected under the SDOH category from the SNF QRP beginning with the FY 2027 SNF QRP without modification.

D. Reconsideration Request Policy and Process

1. Background

In the FY 2016 SNF PPS final rule (80 FR 46460 and 46461), we finalized the SNF QRP Reconsideration policy and process whereby a SNF may request reconsideration of an initial determination that the SNF did not comply with the SNF QRP reporting requirements, warranting the reduction of the SNF's annual market basket percentage by 2 percent for the applicable FY as required by section 1888(e)(6)(A) of the Act. In that rule, we stated that the SNF may file a request for reconsideration if they believe that the finding of noncompliance is erroneous, have submitted a request for extension or exception that has not yet been decided, or have been granted an extension or exception (80 FR 46460). We further finalized that, as part of the SNF's request for reconsideration, the SNF must submit all supporting documentation and evidence demonstrating full compliance with all SNF QRP reporting requirements for the applicable FY, that the SNF requested an extension or exception for which a decision has not yet been made, that the SNF has been granted an extension or exception, or the SNF has experienced an extenuating circumstance as defined in the FY 2016 SNF PPS final rule for the ECE policy (80 FR 46459) but failed to file a timely request of exception (80 FR 46460). We finalized that we would not review any reconsideration request that fails to provide the necessary documentation and evidence along with the request (80 FR 46460).

In the FY 2016 SNF PPS final rule, we provided that a SNF generally must submit its request for reconsideration within 30 days from the date of initial notification of noncompliance (80 FR 46460). However, we finalized that, in very limited circumstances, we may grant a request by a SNF to extend the 30-day deadline for their reconsideration requests (80 FR 46460). We stated that, to extend the deadline, SNFs would have to request an extension and demonstrate that ''extenuating circumstances'' prevented the filing of the reconsideration request by the 30-day deadline (80 FR 46460).

We finalized other procedural requirements for SNFs to request a reconsideration in the FY 2016 SNF PPS final rule, including submission of their request via electronic mail to CMS (80 FR 46460 and 46461). We also provided that, if a SNF is dissatisfied with our decision regarding their reconsideration request, the SNF may file an appeal

with the Provider Reimbursement Review Board (80 FR 46461).

In the FY 2018 SNF PPS final rule (82 FR 36606; 82 FR 36634 and 36635), we codified the SNF QRP's reconsideration policy, as previously finalized, at § 413.360(d). Subsequently, we have finalized minor amendments to § 413.360(d)(1) and (d)(4) to reflect updates to our methods for communicating our notifications of noncompliance and reconsideration request decisions (83 FR 39270 and 39271; 83 FR 39290; 84 FR 38817; 84 FR 38832 and 38833).

Section 413.360(d) addresses how we send our written notification of noncompliance to a SNF, the process for a SNF to request reconsideration, what information a SNF must include with its reconsideration request (for example, reason(s) for requesting reconsideration, including all supporting documentation), that we will not consider a reconsideration request unless the SNF has complied fully with the procedural requirements, and how we notify the SNF of our final decision regarding its reconsideration request.

In the proposed rule, we sought to clarify the inconsistencies in our preamble and regulation text regarding SNF requests for reconsideration.

2. Allow SNFs To Request an Extension To File a Request for Reconsideration

As previously stated, in the FY 2016 SNF PPS final rule, in limited circumstances, we may grant a request by a SNF to extend the deadline to submit its reconsideration request, so long as the SNF requested the extension and demonstrated that extenuating circumstances existed that prevented it filing a reconsideration request by the 30-day deadline (80 FR 46460). We did not codify this policy, permitting SNFs to request an extension to file their reconsideration request, at § 413.360(d). In implementing this finalized policy, we have recognized two areas where further clarity would be beneficial to SNFs.

First, we have not clearly defined or explained the term ''extenuating circumstances'' as used in our reconsideration policy. In contrast, we use the term ''extraordinary circumstances'' in our Extraordinary Circumstances Exception and Extension (ECE) policy, at § 413.360(c). We did explain ''extraordinary circumstances'' in detail when we originally finalized this ECE policy in the FY 2016 SNF PPS final rule (80 FR 46459).

On this basis, we proposed to remove the term ''extenuating circumstances'' as used currently in our reconsideration policy and replace it with ''extraordinary circumstances.'' Specifically, we proposed that a SNF may request, and CMS may grant, an extension to file a reconsideration request if the SNF was affected by an extraordinary circumstance beyond the control of the SNF (for example, a natural or man-made disaster). By modifying the basis by which a SNF may request an extension to file a reconsideration request in this manner, we also proposed to incorporate our prior explanation regarding the meaning of extraordinary circumstances, as set forth in the FY 2016 SNF PPS final rule (80 FR 46459) as part of our Extraordinary Circumstance Exception and Extension (ECE) policy.

Second, we recognized areas in our policy where SNFs may benefit from clearly demarcated deadlines. Although we believe a SNF would have an interest in requesting for an extension to file a reconsideration request prior to the deadline, our policy currently does not specify a deadline for a SNF to submit its request for such an extension (80 FR 46460). Our policy also provides that, to support such request, the SNF must demonstrate that extenuating circumstances existed that prevented filing the reconsideration request by the 30-day deadline (80 FR 46460). However, we have not specified a temporal relationship between when the extenuating circumstances occurred and the reconsideration request deadline. We believe SNFs may benefit from further specificity regarding these requirements for submitting a request to extend the deadline to file a reconsideration request.

On this basis, we proposed to amend our reconsideration policy at § 413.360(d) to permit a SNF to request, and CMS to grant, an extension to file a request for reconsideration of a noncompliance determination if, during the period to request a reconsideration as set forth in § 413.360(d)(1), the SNF was affected by an extraordinary circumstance beyond the control of the SNF (for example, a natural or man-made disaster). We proposed that the SNF must submit its request for an extension to file a reconsideration request to CMS via email to *SNFQRPReconsiderations@cms.hhs.gov* no later than 30 calendar days from the date of the written notification of noncompliance. We proposed that the SNF's extension request, submitted to CMS, must contain all of the following information: (1) the SNF's CCN; (2) the SNF's business name; (3) the SNF's business address; (4) certain contact information for the SNF's chief executive officer or designated personnel; (5) a statement of the reason for the request for the extension; and (6) evidence of the impact of the extraordinary circumstances, including, for example, photographs, newspaper articles, and other media. We proposed this process at § 413.360(d)(5).

We further proposed that we will notify the SNF in writing of its final decision regarding its request for an extension to file a reconsideration of noncompliance request via an email from us. We proposed to notify the SNF in writing via email because this will allow for more expedient correspondence with the SNF, given the 30-day reconsideration timeframe. We proposed this process at § 413.360(d)(6).

We are considering similar proposals across all post-acute care setting quality reporting programs to more closely align the reconsideration processes. On average, over the last 3 years, we have received 202 reconsideration requests annually from SNFs. If all these SNFs submitted an extension to file a reconsideration request to us, we estimated 51 hours total of administrative burden at an increased cost of $2,391.90 for these SNFs in the proposed rule (90 FR 18606). We refer readers to section IX.A.6.b. of this final rule for details on this estimated increase in burden.

The following is a summary of the public comments received on the proposals to amend the SNF QRP reconsideration policy to permit SNFs to request an extension to file a reconsideration request at §§ 413.360(d)(5) and (d)(6), along with our responses.

Comment: Several commenters expressed their support for this proposal. A few commenters noted their support and appreciation for CMS increasing clarity and consistency among program policies. One commenter agreed that flexibility with requesting reconsideration, including filing extensions, will help SNFs better manage disasters.

Response: We thank commenters for their support.

Comment: A few commenters were supportive of our efforts to clarify the reconsideration request process but expressed some concerns. Several of these commenters had concerns regarding shortening the request timeframe to 30 days. Two of these commenters stated that during an emergency, facility leadership must focus on patient safety. They stated that CMS should allow for flexible, case-by-case deadline extensions. One of these commenters suggested that the extensions be case-by-case but not exceed 4.5 months. Another commenter suggested the reduction to 30 days may

be insufficient as a hospital may still be dealing with a disaster during that time frame and suggested that CMS should set the minimum timeframe at no less than 60 days.

Response: We appreciate the commenters' concerns and recommendations, though we find aspects of the comments to be unclear. We interpret the commenters to mean that they believed our proposed 30-day deadline would apply to the exception and extension (ECE) process for data submission, rather than the reconsideration process following a determination of noncompliance. To clarify, the ECE policy—which applies during the reporting period—allows SNFs 90 days from the date of an event occurring due to extraordinary circumstances to request an exception or extension for data submission (§ 413.360(c)(2)). We did not propose to modify that 90-day timeframe under this proposal or otherwise in the FY 2026 SNF PPS proposed rule.

We wish to clarify that this proposal does not reduce the window for a SNF to request an exception or extension for data submission during the reporting year. Rather, this proposal only speaks to the annual Reconsideration request process. Because our policy did not specify a deadline for a SNF to submit its request for such an extension (80 FR 46460), we are providing a clear timeframe of 30 days for this process.

We proposed to establish and codify that SNFs impacted by an extraordinary circumstance beyond the control of the SNF have 30 calendar days from the date of the written notification of noncompliance to submit a request for an extension to file a reconsideration request; this would be separate from the ECE policy that applies to SNFs. SNFs would still have 90 days to submit an exception and extension request from the time of an event occurring due to extraordinary circumstances (§ 413.360(c)(2)), and 30 days from the initial notification of noncompliance to submit a request for reconsideration (§ 413.360(d)(1)).

This proposal introduces a new, clearly defined process for requesting an extension to file a reconsideration request—something not previously codified. We interpret the commenters' concern as reflecting the absence of a clear process in the past, and we believe formalizing a 30-day timeframe will help ensure transparency and consistency across SNFs.

We further believe that this process helps reduce administrative burden in the context of extraordinary circumstances. By enabling SNFs to request more time to prepare a reconsideration submission when needed, this proposal is designed to offer flexibility—not restrict it.

Regarding commenters' requests to extend the timeframe, we believe that the 30-day timeframe for requesting an extension to file a reconsideration request is appropriate for the SNF QRP. This 30-day timeframe allows for the opportunity to resolve issues early in the process when we have dedicated resources to considering all reconsideration requests before payment changes are applied to SNFs annual payment. It also aligns with the reconsideration extension request deadlines being proposed for the IRF QRP (90 FR 18551 through 18553) and LTCH QRP (90 FR 18350 through 18352).

Comment: A couple commenters were supportive of the proposed changes but expressed concerns about the overall reconsideration process. One of these commenters expressed concerns over the estimated increase in burden for SNFs that request an extension to file a reconsideration request. This commenter suggested that CMS streamline the process through simplifying the application process, providing clearer guidance on documentation types, or offering technical assistance to SNFs unfamiliar with the process. Another of these commenters agreed with clarifying the process and recommended that CMS issue subregulatory guidance on expectations and documentation requirements.

Response: We appreciate the commenters' concerns and recommendations. This proposed policy update does not add any additional burden to the majority of SNFs; only those who request an extension to file a reconsideration request. Permitting a SNF to request an extension to file a reconsideration may ultimately relieve burden for the SNF faced with extraordinary circumstances by giving them more time to put together their reconsideration application if such an event were to occur. Regarding the comments recommending that we issue subregulatory guidance to clarify expectations and documentation requirements, we are committed to ensuring transparency and will consider whether additional guidance is needed to support SNF providers in understanding and meeting these requirements. We will continue to engage with interested parties and evaluate the need for subregulatory materials to facilitate consistent application and compliance across SNFs.

Comment: One commenter opposed the proposal to replace ''extenuating circumstances'' with ''extraordinary circumstances'' as they noted ''extenuating'' provides a flexible standard that matches the variability of SNF environments. This commenter stated it was unlikely that SNFs are taking advantage of the standard outside of when it is necessary. They recommended that CMS keep the reconsideration process fair, accessible, and grounded in a standard that allows good faith challenges to succeed.

Response: As stated in the proposed rule, we have not clearly defined or explained the term ''extenuating circumstances'' as used in our reconsideration policy (90 FR 18606). Conversely, we use the term ''extraordinary circumstances'' in our Extraordinary Circumstances Exception and Extension (ECE) policy, at § 413.360(c). We did explain ''extraordinary circumstances'' in detail when we originally finalized this ECE policy in the FY 2016 SNF PPS final rule (80 FR 46459). We believe aligning this language across the two processes provides increased clarity for SNFs regarding the requirements for submitting a reconsideration request and allows for acceptable flexibility.

Additionally, we want to align with other post-acute quality reporting programs' policies and processes regarding reconsideration.[4] [5] Our intent is to allow for the SNF QRP, as well as the IRF QRP and LTCH QRPs, to file a reconsideration request in the event of extraordinary circumstances beyond the control of the facility (for example, a natural or man-made disaster).

After consideration of the public comments, we are finalizing our proposal to amend the SNF QRP reconsideration policy to permit SNFs to request an extension to file a reconsideration request, and to codify this proposed policy and process at §§ 413.360(d)(5) and (d)(6), without modification.

[4] Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program: *https://www.federalregister.gov/documents/2025/04/30/2025-06336/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal#h-35.*

[5] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes: *https://www.federalregister.gov/documents/2025/04/30/2025-06271/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.*

3. Update the Bases on Which CMS Can Grant a Reconsideration Request

As previously stated, in FY 2016 SNF PPS final rule (80 FR 46460), the SNF may file a request for reconsideration if they believe that the finding of noncompliance is erroneous, have submitted a request for extension or exception that has not yet been decided, or have been granted an extension or exception (80 FR 46460). We further finalized that, as part of the SNF's request for reconsideration, the SNF must submit all supporting documentation and evidence demonstrating full compliance with all SNF QRP reporting requirements for the applicable FY, that the SNF requested an extension or exception for which a decision has not yet been made, that the SNF has been granted an extension or exception, or the SNF has experienced an extenuating circumstance as defined in the FY 2016 SNF PPS final rule for the ECE policy (80 FR 46459) but failed to file a timely request of exception (80 FR 46460). We also finalized in the FY 2016 SNF PPS final rule that we would not review any reconsideration request that fails to provide the necessary documentation and evidence along with the request (80 FR 46460).

As previously stated, we codified our reconsideration policy at § 413.360(d) in the FY 2018 SNF PPS final rule (82 FR 36606; 82 FR 36634 and 36635). Section 413.360(d)(2)(vi) requires that a SNF's request for reconsideration include the reason(s) for requesting reconsideration including all supporting documentation. Section 413.360(d)(3) provides that we will not consider a reconsideration request unless the SNF has complied fully with the requirements of § 413.360(d)(2), governing submission of its reconsideration request. We will notify the SNF in writing regarding our final decision on its reconsideration request in accordance with § 413.360(d)(4). We believe it would be beneficial for SNFs if we codify our specific bases for granting a reconsideration request in our regulation at § 413.360(d).

We proposed to modify our reconsideration policy to provide that we will grant a timely request for reconsideration, and reverse an initial finding of non-compliance, only if CMS determines that the SNF was in full compliance with the SNF QRP requirements for the applicable program year. We stated that we would consider full compliance with the SNF QRP requirements to include us granting an exception or extension to SNF QRP reporting requirements under our ECE policy at § 413.360(c) (90 FR 18607). However, to demonstrate full compliance with our ECE policy, we stated that the SNF would need to comply with our ECE policy's requirements, including the specific scope of the exception or extension as granted by us (90 FR 18607).

We proposed to revise § 413.360(d)(4) to modified policy in our regulation. We proposed that the remainder of the text at § 413.360(d)(4) would remain the same. We noted that we are considering similar proposals across all post-acute care quality reporting programs to more closely align the reconsideration policies and processes.

We solicited comments on our proposals to amend, and codify at § 413.360(d)(4), the bases by which we grant a reconsideration request under the SNF QRP Reconsideration policy.

The following is a summary of the public comments received on the proposal to amend, and codify at § 413.360(d)(4), the bases by which we grant a reconsideration request under the SNF QRP Reconsideration policy, along with our responses.

Comment: One commenter requested that CMS account for technical errors made while fulfilling compliance requirements and consider a materiality threshold for technical errors that do not impact care quality.

Response: We appreciate the suggestion to account for technical errors made in good faith when fulfilling compliance requirements and to consider a materiality threshold for errors that do not impact care quality. While we recognize that some facilities may experience unintended technical issues during data submission, we believe it is critical to maintain consistent standards to ensure the accuracy and completeness of quality data across SNFs. We will consider whether there are opportunities to clarify how technical errors are evaluated within the reconsideration process, while continuing to prioritize data integrity and fair application of reporting requirements.

We are finalizing our proposals to amend the bases by which we grant a reconsideration request under the SNF QRP Reconsideration policy and codify this policy at § 413.360(d)(4), with a minor technical modification to refer to the regulated entity in the singular instead of plural form (that is, the SNF instead of SNFs).

E. SNF QRP Measure Concepts Under Consideration for Future Years—Request for Information (RFI): Interoperability, Well-Being, Nutrition & Delirium

In the FY 2026 proposed rule, we solicited comments on the importance, relevance, appropriateness, and applicability of each of the quality measure concepts under consideration listed in Table C13 for future years in the SNF QRP. As we review new measure concepts, CMS will prioritize outcome measures that are evidence-based. In the FY 2025 SNF PPS proposed rule (89 FR 23468 through 23469), we included an RFI on a set of principles for selecting and prioritizing SNF QRP measures, identifying measurement gaps, and suitable measures for filling these gaps. We refer readers to the FY 2025 SNF PPS final rule (89 FR 64112 through 64114) for a summary of the public comments received in response to the RFI.

We refer readers to the FY 2026 SNF PPS proposed rule (90 FR 18607 through 18608) for a description of each of the quality measure concepts under consideration for this RFI. The following is a summary of the comments received on the RFI regarding four concepts for future measures for the SNF QRP, along with our response received public comments on this RFI.

TABLE 13: Future Measure Concepts Under Consideration for the SNF QRP

Quality Measure Concepts
Interoperability
Well-being
Nutrition
Delirium

1. Interoperability

Comments: Several commenters supported a measure of interoperability, saying that seamless exchange of information across case settings is critical for timely care and safety and improves care coordination and communication. These commenters noted the effort to capture the extent of adoption of these systems is a step towards encouraging interoperability. Commenters noted the importance of interoperability between communicating parties, across care settings, and its importance for data collection and use.

Several commenters stressed the importance of understanding the current state of data interoperability among SNFs. Two commenters stated that SNFs may have trouble with interoperable data exchange because of their reliance on certified EHR technology (CEHRT) and uneven adoption across PAC settings. A couple of these commenters noted the broad range of capabilities across SNFs, stating that some use advanced EHRs while others rely on paper records. These commenters also stated that the scale and complexity required for true interoperability is a barrier as crucial details, such as maintaining an up-to-date SNF provider directory, need to be addressed first. Another commenter stated that some licensed healthcare professionals have limited data capture in EHR systems, and that limitation can cause their contributions to care quality and outcomes to be overlooked. Two more commenters emphasized that adoption of EHR in residential settings is limited, modernization remains slow, and that CMS may be overestimating the readiness and abilities of SNFs related to interoperability. Additional commenters stated CMS needs to consider the lack of uniform standards in EHR systems and the inconsistent data formatting before they implement an interoperability measure. A sixth commenter shared that a limited number of hospitals are able to send interoperable health information to SNFs and work arounds using not standardized or interoperable approaches are commonplace when sharing between care partners. Finally, one commenter stated that workforce readiness impacts achieving interoperability, as frontline staff often default to manual processes over electronic ones.

A few commenters were concerned that SNFs do not currently have the financial or technical infrastructure to support robust interoperability. A few commenters noted that SNFs were not eligible for incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Act (Pub. Law 111–5) and without those incentives there are significant financial barriers to health IT adoption. Commenters recommended that CMS should provide financial/technical support, identify sustainable funding mechanisms, or develop incentives and grant opportunities specifically targeting rural and nonprofit SNFs to accelerate interoperability while avoiding unfunded mandates. One commenter recommended providing additional funding through the New Technology Add-on Payments Program or through the Civil Money Penalty Reinvestment Program. Other commenters suggested CMS build upon the HITECH model to provide support for those previously excluded from the model.

Several commenters wrote in opposition to an interoperability measure at this time. One commenter suggested that CMS should focus initial interoperability efforts on upstream partners, like hospitals and state health departments, before implementing measures for SNFs. Another commenter opposed a future interoperability measure stating that the measure would increase administrative burden in a way that nursing homes are not equipped to undertake at this time. A second commenter opposed adding new measures that increase burden without demonstrated improvement in outcomes. A third commenter opposed the creation of the measure, as interoperability requirements are already governed by the Information Blocking regulations. This commenter recommended CMS focus on quality-of-care measures and stated that a measure of interoperability would not necessarily help clinicians improve their care quality. A fourth commenter expressed that the variation in technology use at SNFs does not inherently reflect variation in the quality of care being provided.

Commenters recommended that the developed measure focus on measuring implementation of interoperability. One commenter recommended that CMS consider existing interoperability measures of successful implementation of interoperability. A second commenter stated that CMS might consider measuring participation in the federal health IT initiative. Another commenter recommended that CMS should utilize existing items already collected in the MDS when developing the new measure. A couple of commenters recommended CMS examine the effectiveness of previous policies and encouraged alignment with other interoperability programs in different QRPs. Two commenters mentioned an instrument they had developed that could assess adoption of EHRs and suggested the instrument could be helpful to CMS in understanding where SNFs are with EHR adoption. A few commenters provided support for the Post-Acute Care InterOperability (PACIO) project,[6] noting its promise in advancing interoperable health data exchange in post-acute care, and recommended CMS continue their support of the project. A few of these commenters suggested CMS consider a phased approach and pair the measure with resources, support, and financial incentives. Another commenter recommended that Automated Dispensing Cabinets be added within the scope of the measure as optimizing medication management in a vulnerable population is important. Lastly, a commenter recommended that an interoperability measure should be informed by the use of automated exchange metrics to support validation and reporting of the measure, instead of manual attestation of interoperability by facilities. This commenter also recommended an interoperability measure that captures workflow transformations in a facility, such as the number of paper or manual processes that have been converted to interoperable exchanges. This commenter recommended the measure use a stepwise approach that measures performance based on the SNFs level of interoperability maturity.

Several commenters stated that CMS should not penalize SNFs based on the measure of interoperability and that the goal of the measure should be to collect information and identify gaps and challenges. One commenter recommended that the developed measure should only be used for public reporting or quality improvement organizations support purposes, stating there is value in being able to compare interoperability capabilities and value in quality improvement organizations having the necessary information to identify and support SNFs in their digital development. Other commenters believe that public reporting should include context about the facility's infrastructure, progress toward interoperability, and commitment to quality. A third commenter believes CMS should not publicly report data for individual SNFs but instead suggest state or regional aggregated reporting.

[6] For more information on the Post-Acute Care InterOperability (PACIO) project, see: *https://pacioproject.org/.*

One commenter recommended several steps they believe are necessary to facilitate interoperability growth before holding SNFs accountable through public reporting and penalties associated with an interoperability measure. These steps included collaborating with interested parties to establish how CMS will determine a SNF's digital capabilities, focusing on intentional and incremental approaches to adopting policy and health IT specifications, considering the complexities of relationships with other healthcare partners, and recognizing the differences in patient populations and care needs

2. Well-Being

Comments: Several commenters supported well-being as a future concept under the SNF QRP and expressed the value in having a measure that captures patient states holistically and informs patient's needs and goals. A few commenters cautioned CMS that well-being will be difficult to define and encouraged the assessment of well-being through validated measures. One commenter emphasized that a measure on well-being should exist alongside SDOH measures and not supplant them. Another commenter supported the measure but cautioned that it seemed more subjective and therefore difficult to standardize, and that CMS should utilize existing well-being related data and existing measures. One commenter stated that the use of existing tools should be standardized. Another commenter voiced similar concerns, citing the possibility for redundancy and expanding beyond the scope of the IMPACT Act. One commenter stated that a clarified goal is required to determine the best tool to capture data for a well-being measure.

A few commenters provided recommendations for CMS to include palliative care for SNF patients within a well-being measure, and to tailor the measure to be modifiable based on the patient's clinical situation and their goals, preferences, and living situation after leaving SNF care. Other commenters recommended roles and staff members that may be best suited to implement and track factors related to well-being (for example, recreational therapists, occupational therapists, registered dietician nutritionists, social workers, and activity planning staff).

A few commenters questioned whether a single, standardized item could meaningfully capture a resident's emotional or psychosocial status and recommended that CMS consider reinstating the full Patient Health Questionnaire-9 (PHQ–9) interview, which was recently scaled back. One commenter recommended setting it up as a patient-reported outcome. Other commenters recommended other measures and tools, for example, PROMIS® (Patient-Reported Outcomes Measurement Information System) measures and the Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (''Feeling Heard and Understood'') quality measure within the Merit-based Incentive Payment System (MIPS) or pointed to using data already collected by SNFs (for example, items in Section GG in the MDS). One commenter recommended CMS consider the impact of pain on patient well-being.

Some commenters cautioned against implementing new measures without demonstrated improvement in outcomes. One commenter emphasized that this puts smaller and more rural SNFs at risk of penalties for community-level factors they cannot influence, and another commenter stated that factors related to SDOH and well-being are not reflective of the quality of care delivered in the facility and are out of the SNF's control. Other commenters stated potential increases in burden on SNF and their staff.

3. Nutrition

Comment: A few commenters voiced their support of the nutrition measure. One commenter stated the importance of nutrition screenings and individualized input. Another commenter emphasized the role of nutrition in protecting independence, functional ability, and quality-of-life through proper preventative care and therapy. Other commenters stated that it is important to address nutrition but encouraged CMS to use data elements already in place to assess nutrition thereby reducing SNF provider burden.

A couple of commenters recommended staff that would be best suited to implement the measure (for example, registered dieticians, nutritionists, speech language pathologists for the treatment of swallowing and feeding disorders). Another commenter supported measuring nutrition, citing that malnutrition can worsen health conditions and lead to higher rates of hospital readmissions, and encouraged CMS to prioritize measures that link nutrition status to care plans, leverage interdisciplinary workflows, and minimize redundancy. Some commenters recommended tools for CMS's consideration. Another commenter recommended that a nutrition measure should consider the amount of money facilities spend on food per resident, the nutritional content of food in nursing homes, food safety, resident satisfaction, and job satisfaction of support staff. Another commenter supported the measure if it utilizes existing nutrition-related data and existing measures.

Some commenters had concerns about the measure concept. One commenter cautioned CMS that nutrition measures will require additional considerations that vary by patient, including quantity of sleep and type of physical activity. A few commenters had concerns about cultural preferences, dietary restrictions, and lifelong eating patterns that are outside the SNFs control. One commenter stated that SNFs should not be penalized based on nutritional outcomes.

Other commenters opposed the nutrition measure as it may not be a meaningful reflection of the SNF care given to residents. A few commenters opposed nutrition, stating that it is not aligned with the purpose and scope of a SNF stay. Another commenter stated that the concept is vague, and it does not clearly differentiate between the needs of beneficiaries requiring short-term or long-term care, or the needs of the beneficiary after they have returned to the community. They recommended several SNF 5-Star quality measures that address the concept of nutritional status for use in the SNF QRP. Another commenter stated that this overlaps with existing measures and would increase burden.

4. Delirium

Comment: Several commenters supported a delirium measure in the SNF QRP, stating it offered clinical value, and that delirium is alarmingly common in SNFs. One commenter recommended using Digital Quality Measures (dQMs) to help track the symptoms.

A few commenters stated that the adoption of a delirium measure in the SNF QRP could leverage existing items on the MDS, such as the validated Confusion Assessment Method (CAM). One commenter voiced limitations on how the CAM will cover fewer symptom domains than specialized tools and that there could be reliability concerns with untrained staff administering the assessments. Another commenter voiced similar concerns, stating restrictive reporting requirements of the MDS mean the CAM is completed too infrequently to capture or monitor for delirium in real-time. A few commenters suggested assessment tools for CMS to consider including the Delirium-O-Meter, CAM–S Confusional State Examination, Delirium

Observation Scale, Delirium Rating Scale, Memorial Delirium Assessment Scale and INTERACT (Interventions to Reduce Acute Care Transfers).

A few commenters cautioned that delirium frequently arises from factors outside the direct control of the SNF (for example, resulting from infection, illness, medication changes, or even a change in the environment) and may not accurately reflect SNF performance. While SNF staff need to closely monitor and address symptoms of delirium, it should not be a condition for which quality is measured. Though supportive of a delirium measure, one commenter cautioned that detection is often underreported, and they recommended that delirium incidence alone should not be the quality metric as this would be inaccurate. Another commenter noted that a delirium measure should promote the SNF working with the hospitals prior to discharge to the SNF, since patients often have delirium upon SNF admission.

Several commenters opposed including delirium in future concepts under the SNF QRP. Some commenters stated that reporting the measure may add reporting burden and that delirium is difficult to monitor and quantify, which would impact the feasibility of this concept as a standardized quality measure. One commenter noted the impact that additional QRP measures generally could have on small, rural SNFs.

Response: We thank all the commenters for responding to this RFI. While we are not responding to specific comments in response to the RFI in this final rule, we will take this feedback into consideration for our future measure development efforts for the SNF QRP.

F. Final Data Submission Deadline From 4.5 Months to 45 Days—Request for Information (RFI)

Sections 1899B(f) and (g) of the Act require CMS to provide feedback to SNFs and to publicly report their performance on SNF quality measures specified under section 1899B(c)(1) of the Act and resource use and other measures specified under 1899B(d)(1) of the Act. More specifically, section 1899B(f)(1) of the Act requires the Secretary to provide confidential feedback reports to SNFs on their performance on the quality, resource use, and other measures specified under section 1899B(c)(1) and (d)(1) of the Act. Section 1899B(f)(2) of the Act provides that, to the extent feasible, the Secretary must make these confidential feedback reports available, no less than on a quarterly basis except in the case of measures reported on an annual basis, in which case confidential feedback reports may be made available annually. Additionally, section 1899B(g)(1) of the Act requires the Secretary to provide for the public reporting of each SNFs' performance on the quality measures, resource use, and other measures specified under sections 1899B(c)(1) and (d)(1) of the Act by establishing procedures for making the performance data available to the public. Section 1899B(g)(2) of the Act specifically requires that such procedures must ensure, including through a process consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) of the Act, that SNFs can review and submit corrections to the data and other information before it is made public.

Although sections 1899B(f) and (g) of the Act require the provision of confidential feedback reports and public reporting of SNF performance on measures, section 1888(e)(6)(B)(i) of the Act provides the Secretary with discretion to prescribe the manner and the timeframes for SNFs to submit data as specified for reporting for the SNF QRP. In the FY 2017 SNF PPS final rule (81 FR 52042 and 52043), we finalized that SNFs will have approximately 4.5 months after each quarterly data collection period to complete their data submissions and make corrections to such data where necessary. At that time, we received several comments supporting the alignment of the data submission and correction timeframes with other quality reporting programs, but we did not receive any comments on the 4.5-month data submission timeframe. We refer readers to the FY 2017 SNF PPS final rule (81 FR 52041 through 52043) for a detailed discussion of our proposal and summary of comments received and responses thereto.

Public reporting of data collected under quality programs, such as the SNF QRP, is designed to provide consumers and their families with the most current information so they can make quality-informed decisions about where to receive their care. In the process of implementing the public reporting for the quality reporting programs, we have identified that the time between when data on measures is collected and submitted to us and when that data are publicly reported (that is, approximately 9 months) may be too long to provide the most accurate and up to date information for the public. For example, through technical expert panels, we have received feedback from patient caregiver advocates that the aged data used in publicly reported quality measures diminishes their value to consumers. Furthermore, we have heard from SNFs that the SNF QRP measure results they receive prior to public reporting are not useful for their quality improvement efforts due to the aged data and the delay in when they receive these reports.[7]

Currently, the largest contributing factor to the 9-month lag between the end of the data collection period and when measures are publicly reported is the 4.5-month timeframe for data submission. If the data submission timeframe was reduced from 4.5 months to 45 days, then the lag time between the end of the data collection period and public reporting of that data could be reduced by up to 3 months. This revised timeframe would result in more timely public reporting of data that may provide more value for consumers and families as they make decisions about where they may want to receive their care. Additionally, this timeframe provides SNFs with more recent data to use in their quality improvement activities.

An important consideration in reducing the data submission timeframe is the potential burden it may place on SNFs, which could lead to fewer assessments submitted within the shorter 45-day data submission timeframe. We conducted an analysis to evaluate the potential impact of reducing the timeframe by determining how many assessments are currently being submitted within 45 days. Using 2023 data, we identified that only 4.2 percent of all MDS assessments were submitted after the 45-day timeframe. Of those submissions, about two-thirds (or 2.8 percent of the total MDS assessments submitted) were submitted between 45 days and 4.5 months and hence have potential to be impacted.[8] On these bases, we believe reducing the SNF QRP data submission deadline from 4.5 months to 45 days will improve the timeliness of public reporting by one quarter, which could be beneficial to both consumers and SNFs, with limited change in burden to SNFs.

We requested feedback on the potential future reduction of the SNF QRP data submission deadline from 4.5 months to 45 days that is under consideration. Specifically, we requested comments on:

[7] SNF QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer. Available in the Downloads section of the SNF QRP Measures and Technical Information web page: *https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information.*

[8] Internal CMS analysis of FY 2023 MDS assessment data.

- How this potential change could improve the timeliness and actionability of SNF QRP quality measures;
- How this potential change could improve public display of quality information; and
- How this potential change could impact SNF workflows or require updates to systems.

We stated in the proposed rule that we intend to use this input to inform our program improvement efforts.

The following is a summary of the public comments received on the RFI regarding the submission deadline along with our responses.

Comments: A few commenters supported the reduction of the data submission timeframe, stating that timelier submission will improve the accuracy of the assessments and facilitate the communication of clinical feedback to SNFs more quickly. A few commenters stated that most facilities already comply with this timeframe and believed this change would have minimal impact on SNF provider burden.

Several commenters supported a change in the timeframe because it would result in more timely public reporting. A few commenters shared that SNFs, and other interested parties have complained that the publicly reported measures are outdated and less meaningful or useful for quality improvement, and that they provide inaccurate information to the public about the quality of care in a given nursing home. These commenters agreed that a shortened time frame will prove more valuable for consumers, professionals, and facilities.

One commenter stated that this change aligns with CMS's digital quality measurement (dQM) goals by reducing reliance on retrospective data and bolstering public trust through timely updates to Care Compare. They believe that FHIR®-enabled APIs can streamline data flows to the internet Quality Improvement and Evaluation System (iQIES), ensuring rapid validation and public posting.

Several commenters had concerns about a reduction in the data submission timeframe, citing increased SNF burden as a key concern. A few of these commenters believed that a 66.67 percent reduction in reporting time is drastic and unrealistic. Several commenters were concerned that this could make it difficult to meet data completion and accuracy thresholds and lead to a decrease in the number of assessments submitted. These commenters cited current SNF staffing challenges and overwhelmed MDS coordinators, believing that the stress on SNF providers outweighs the value of timelier data. A few commenters stated that the reduced submission window is likely to result in higher error rates since it reduces the time available for internal data validation and review. One commenter stated that the change to 45 days will only hasten the rate of data collection and not the use of data in SNF QRP.

A few commenters cited specific circumstances or events that could affect facility compliance. One commenter stated that staff turnover and unforeseen events that do not qualify as Public Health Emergencies (PHEs) may hinder compliance and should be accounted for. Other commenters voiced concerns that SNFs in rural areas and/or with limited resources, size, or technical infrastructure may be disproportionately impacted by the restricted timeframe. These commenters believe that these facilities would be more at risk of penalties and reduced payments if they could not maintain compliance. One commenter emphasized that CMS should allow flexibility for hardship or rural status or provide technical assistance to vulnerable facilities to ensure accuracy and quality.

Several commenters had recommendations for alternate changes to the timeframe. One commenter recommended CMS consider aligning the revised timeline to be consistent with other administrative deadlines (for example, payroll-based journal data for staffing measures). A few commenters recommended CMS consider aligning with the existing Five-Star data pull window of approximately 80 to 90 days post-quarter to reduce confusion, alleviate administrative burdens, and streamline overall work efforts. A few commenters recommended 60 days as an alternative, while others suggested a phased implementation approach, recommending that the reporting deadline should never be fewer than 60 days after the quarter. One commenter suggested that CMS conduct additional analyses and solicit further input from facilities on what timeframe would strike the best balance of feasibility and timeliness.

Some commenters addressed logistical implementation challenges. One commenter, though supportive of efforts to streamline regulations and increase timeliness of data submissions, expressed concern that workflow impacts will require adjustments within a much smaller window, and technological/IT systems will need to be invested in or updated to accommodate new deadlines. Another commenter supported the change if CMS implemented communication and reminders to assist facilities. One commenter recommended that all quality programs align with the revised timeframe.

Response: We appreciate the input provided by commenters. While we are not responding to specific comments submitted in response to this RFI in this final rule, we intend to use this input to inform our program improvement efforts.

G. Advancing Digital Quality Measurement in the SNF QRP—Request for Information (RFI)

As part of our effort to advance the digital quality measurement (dQM) transition, the proposed rule included an RFI to gather broad public input on the dQM transition in SNFs.

1. Background

We are committed to improving healthcare quality through measurement, transparency, and public reporting of quality data, and to enhancing healthcare data exchange by promoting the adoption of interoperable health IT that enables information exchange using Fast Healthcare Interoperability Resources® (FHIR®) standards. We proposed to require the use of such technology within the SNF QRP in the future could potentially enable greater care coordination and information sharing, which is essential for delivering high-quality, efficient care and better outcomes at a lower cost. In the FYs 2021, 2022, 2023, and 2024 SNF PPS proposed rules,[9] we outlined several Department of Health and Human Services (HHS) initiatives aimed at promoting the adoption of interoperable health IT and facilitating nationwide health information exchange. Further, to inform our digital strategy, in the FY 2022 SNF PPS proposed rule (86 FR 19998) we shared and sought feedback on the following:

- Our intent to explore the use of FHIR®-based standards to exchange clinical information through application programming interfaces (APIs).
- Enabling quality data submission to CMS through our internet Quality Improvement and Evaluation System (iQIES).

[9] ''Advancing Health Information Exchange'' in: FY 2021 SNF PPS proposed rule (85 FR 20915) *https://www.federalregister.gov/documents/2020/04/15/2020-07875/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities#p-60,* FY 2022 SNF PPS proposed rule (86 FR 19956) *https://www.federalregister.gov/d/2021-07556/p-64,* FY 2023 SNF PPS proposed rule (87 FR 22721) *https://www.federalregister.gov/d/2022-07906/p-78,* and FY 2024 SNF PPS proposed rule (88 FR 21318) *https://www.federalregister.gov/d/2023-07137/p-76.*

• To work with healthcare standards organizations to ensure their standards support our assessment tools.

We considered opportunities to advance FHIR®-based reporting of resident assessment data for the submission of the MDS and other existing systems such as CDC's National Healthcare Safety Network (NHSN) for which SNFs have current CMS reporting requirements. Our objective is to explore how SNFs typically integrate technologies with varying complexity into existing systems and how this affects SNF workflows. In the proposed rule, we issued this RFI and sought input to identify the challenges and/or opportunities that may arise during this integration, and determine the support needed to complete and submit quality data in ways that protect and enhance care delivery.

We also solicited input on future measures under consideration including applicability of interoperability as a future measure concept in post-acute care settings, including the SNF QRP. We refer readers to the proposed rule (90 FR 18607) for more information.

Any updates specific to the SNF QRP program requirements related to quality measurement and reporting provisions will be addressed through separate and future notice-and-comment rulemaking, as necessary.

2. Solicitation for Comment

We solicited comments on the current state of health IT use, including electronic health records (EHRs), in SNF facilities:

• To what extent does your SNF use health IT systems to maintain and exchange resident records? If your facility has transitioned to using electronic records in part or in whole, what types of health IT does your SNF use to maintain resident records? Are these health IT systems certified under the Office of the National Coordinator for Health Information Technology (ONC Health IT) Certification Program? If your facility uses health IT products or systems that are not certified under the ONC Health IT Certification Program, please specify. Does your facility use EHRs or other health IT products or systems that are not certified under the ONC Health IT Certification Program? If no, what is the reason for not doing so? Do these other systems exchange data using standards and implementation specifications adopted by HHS? Does your facility maintain any resident records outside of these electronic systems? If so, are the data organized in a structured format, using codes and recognized standards, that can be exchanged with other systems and providers?

• Does your SNF submit resident assessment data to CMS directly from your health IT system without the assistance of a third-party intermediary? If a third-party intermediary is used to report data, what type of intermediary service is used? How does your facility currently exchange health information with other healthcare providers or systems, specifically between SNFs and other provider types? What about health information exchange with other entities, such as public health agencies? What challenges do you face with electronic exchange of health information?

• Are there any challenges with your current electronic devices (for example, tablets, smartphones, computers) that hinder your ability to easily exchange information across systems? Please describe any specific issues you encounter. Does limited internet or lack of internet connectivity impact your ability to exchange data with other healthcare providers, including community-based care services, or your ability to submit resident assessment data to CMS? Please specify.

• What steps does your SNF take with respect to the implementation of health IT systems to ensure compliance with security and patient privacy requirements such as the Health Insurance Portability and Accountability Act (HIPAA)?

• Does your SNF refer to the Safety Assurance Factors for EHR Resilience (SAFER) Guides (see newly revised versions published in January 2025 at *https://www.healthit.gov/topic/safety/safer-guides*) to self-assess EHR safety practices?

• What challenges or barriers does your facility encounter when submitting quality measure data to CMS as part of the SNF QRP? What opportunities or factors could improve your facility's successful data submission to CMS?

• What types of technical assistance guidance, workforce trainings, and/or other resources would be most beneficial for the implementation of FHIR®-based technology in your facility for the submission of the MDS to CMS and other existing systems such as CDC's National Healthcare Safety Network (NHSN) for which SNFs have current CMS reporting requirements? What strategies can CMS, HHS, or other federal partners take to ensure that technical assistance is both comprehensive and user-friendly? How could Quality Improvement Organizations (QIOs) or other entities enhance this support?

• Is your facility using technology that utilizes APIs based on the FHIR® standard to enable electronic data sharing? If so, with whom are you sharing data using the FHIR® standard and for what purpose(s)? For example, have you used FHIR® APIs to share data with public health agencies? Does your facility use any Substitutable Medical Applications and Reusable Technologies (SMART) on FHIR® applications? If so, are the SMART on FHIR® applications integrated with your EHR or other health IT?

• How do you anticipate the adoption of technology using FHIR®-based APIs to facilitate the reporting of resident assessment data could impact provider workflows? What impact, if any, do you anticipate it will have on quality of care?

• What benefits or challenges have you experienced with implementing technology that uses FHIR®-based APIs? How can adopting technology that uses FHIR®-based APIs to facilitate the reporting of resident assessment data impact provider workflows? What impact, if any, does adopting this technology have on quality of care?

• Does your facility have any experience using technology that shares electronic health information using one or more versions of the United States Core Data for Interoperability (USCDI) standard? [10]

• Would your SNF and/or vendors be interested in participating in testing to explore options for transmission of assessments, for example testing the transmission of a FHIR®-based assessment to CMS?

• How could the Trusted Exchange Framework and Common Agreement™ (TEFCA™) support CMS quality programs' adoption of FHIR®-based assessment submissions consistent with the FHIR® Roadmap (available at *https://rce.sequoiaproject.org/three-year-fhir-roadmap-for-tefca/*)? How might resident assessment data hold secondary uses for treatment or other TEFCA™ exchange purposes?

• What other information should we consider to facilitate successful adoption and integration of FHIR®-based technologies and standardized data for patient/resident assessment instruments like the MDS? We invite any feedback, suggestions, best practices, or success stories related to the implementation of these technologies.

We solicited feedback, suggestions, best practices, or success stories related

[10] For more information about USCDI see *https://www.healthit.gov/isp/united-states-core-data-interoperability-uscdi.*

to the implementation of the technologies. We stated in the proposed rule that we will use this input to inform our future dQM transition efforts.

The following is a summary of the public comments received on the RFI along with our responses.

Comments: Many commenters supported the dQM transition and provided recommendations. Several of these commenters recommended a phased or ''glide path'' approach to implementation. Other commenters recommended that CMS adopt a timeline that allows for adequate testing, stakeholder engagement, and resource development. One commenter recommended a minimum of 12 months and a 3-year voluntary phase.

A few commenters recommended that any changes in regulation related to technology should include clear technical specifications and technical assistance. Several commenters recommended that CMS move submission of the MDS to a FHIR®-based API via the iQIES portal to support this transition. One commenter suggested that CMS fund pilot programs for SNFs to test FHIR®-based quality reporting. Another commenter supported moving toward a consistent, single national standard for transmitting quality data and recommended robust testing and pilot deployment. One commenter recommended focusing on efforts to advance interoperability across the care continuum, including SNFs, via electronic data exchange. Another commenter suggested that CMS work with vendors to ensure that their systems are compatible with CMS's requirements.

Several commenters suggested that CMS provide grants or incentives for the adoption of interoperable health IT. A few commenters suggested that CMS account for the varying technical capacity among SNFs, citing their inability to receive funding from programs like Meaningful Use (previously referred to as the Medicare and Medicaid EHR Incentive Programs) and Promoting Interoperability programs (currently referred to as the Medicare Promoting Interoperability Program for eligible hospitals & critical access hospitals). A few commenters had concerns about barriers to health IT, with one of the commenters stating that rural facilities may face significant barriers to internet access and technical infrastructure. Another stated that siloed data infrastructure, training, and workforce development could be financial barriers.

A few commenters had concerns about varying levels of IT and EHR resources among SNFs. One commenter suggested that CMS monitor and account for the varying technical capacity among SNFs. Another commenter requested CMS to clarify how dQM implementation will maintain equity safeguards to avoid favoring SNFs with more resources and better digital infrastructure.

Several commenters provided detailed responses to the RFI's questions about their facility's current state of health IT use, challenges and/or opportunities that may arise during integration of technologies with varying complexity into existing SNF systems, how it affects workflow, and what support may be needed to complete and submit quality data in ways that protect and enhance care delivery.

Response: We thank commenters for their feedback and will use this information to inform the transition to dQM in the SNF QRP.

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

We did not propose any new policies regarding the form, manner, and timing of data submitted under the SNF QRP. We refer readers to the current regulations text at § 413.360(b) for information regarding the policies for reporting specified data for the SNF QRP.

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

We did not propose any new policies regarding the public display of measure data. We refer readers to the FY 2017 SNF PPS final rule (81 FR 52045 through 52048) for a discussion of our policies regarding public display of SNF QRP measure data and procedures for the SNFs to review and correct data and information prior to their publication.

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

A. Statutory Background

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

We received one general comment regarding the SNF VBP Program. The following is a summary of the comment and our response.

Comment: One commenter recommended consolidating the SNF QRP and SNF VBP Program into a single, integrated framework to reduce confusion and ease administrative burden and staffing constraints. For example, the commenter suggested CMS explore the alignment of data submission timelines and review and correction periods.

Response: We acknowledge the commenter's concern and thank the commenter for their feedback. We intend to take this feedback into consideration as part of our SNF VBP Program monitoring and evaluation efforts.

B. Removal of the Health Equity Adjustment From the SNF VBP Program Scoring Methodology

1. Background

In the FY 2024 SNF PPS final rule (88 FR 53304 through 53318), we adopted a Health Equity Adjustment (HEA) that, beginning with the FY 2027 program year, would reward top tier performing SNFs that serve higher proportions of SNF residents with dual eligibility status. We codified the HEA at § 413.338(k) of our regulations. Section 1888(h)(4)(A) of the Act requires the Secretary to develop a methodology for assessing the total performance of each SNF based on performance standards established under section 1888(h)(3) of the Act with respect to the measures applied under section 1888(h)(2) of the Act.

As previously stated in the FY 2024 SNF PPS final rule, by providing the HEA to SNFs that serve higher proportions of SNF residents with dual eligibility status and that perform well on quality measures, we believed the HEA would appropriately recognize the resource intensity expended to achieve high performance on quality measures by SNFs that serve a high proportion of SNF residents with dual eligibility status, while also mitigating the worse health outcomes experienced by dually eligible residents through incentivizing better care across all SNFs.

In the FY 2024 SNF PPS final rule (88 FR 53304 through 53318), we also finalized a variable payback percentage, increasing the total amount available for value-based incentive payments for a FY, beginning with the FY 2027 program year. We codified the increase in the total amount available for value-

based incentive payments as appropriate for each FY to account for the application of the HEA at § 413.338(c)(2)(i). The variable payback percentage would vary by program year to account for the application of the HEA such that SNFs that receive the HEA would receive increased value-based incentive payment amounts, and SNFs that do not receive the HEA would not experience a decrease in their value-based incentive payment amount, to the greatest extent possible, relative to no HEA in the SNF VBP Program and maintaining a payback percentage of 60 percent. That is, the variable payback percentage confirms that a very limited number of SNFs (if any) that do not receive HEA bonus points will experience a downward payment adjustment.

2. Removal of the Health Equity Adjustment Beginning With the FY 2027 Program Year

In the FY 2026 SNF PPS proposed rule (90 FR 18610), we proposed to remove the HEA because we believed simplifying the SNF VBP Program's scoring methodology by removing the HEA would improve SNFs' understanding of the Program and provide clearer incentives for SNFs as they seek to improve their quality of care for all residents. In addition, we estimated that the impact of removing the HEA on overall incentive payment adjustments is small. We conducted an analysis utilizing FY 2018 through FY 2021 measure data for all 8 measures in the FY 2028 program year's measure set, estimating that the average incentive payment multiplier with the HEA would be 0.9924613988 and without the HEA would be 0.9915553875. Given this relatively small, estimated impact, and in light of the Administration's priority to streamline regulations and reduce burdens on those participating in the Medicare program, we proposed to remove the HEA. We refer readers to the Supplementary Information, Unleashing Prosperity Through Deregulation of the Medicare Program—Request for Information section of the FY 2026 SNF PPS proposed rule (90 FR 18590) for more information.

We considered altering the structure of the adjustment methodology to simplify it, but that process will require time to develop and test a new adjustment and, if pursued, would be addressed in future rulemaking.

As stated in the FY 2026 SNF PPS proposed rule (90 FR 18610), we also did not anticipate that any serious reliance interests would be impacted by our proposal to remove the HEA.

We proposed to codify this removal of the HEA by removing §§ 413.338(k) and (e)(3)(iii) from our regulations, removing terms related to the HEA in § 413.338(a) of our regulations, and revising § 413.338(c)(2)(i) of our regulations to remove the variable payback percentage adopted beginning in the FY 2027 program year and instead maintain the 60 percent payback percentage adopted beginning in the FY 2023 program year.

We invited and received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported or had no objection to CMS' proposal to remove the HEA. Two commenters supported the removal of the HEA because of CMS' analysis showing a very small reduction in average incentive payment multiplier and their belief that this reduction did not outweigh the likely confusion and administrative burden created by the HEA. One commenter stated that the HEA resulted in unintended consequences, such as rewarding SNFs with higher proportions of residents with dual eligibility status rather than SNFs that care for higher proportions of residents enrolled only in Medicaid, and supported the removal of the HEA to reduce administrative burden.

Response: We thank the commenters for their support. We agree that the removal of the HEA will have a minor impact on the average incentive payment multiplier and will result in a more efficient and streamlined scoring methodology.

Comment: Many commenters supported or had no objection to CMS' proposal to remove the HEA, but also provided recommendations. Many commenters encouraged CMS to develop an alternative, more comprehensive methodology to support SNFs caring for vulnerable populations, incentivize better access to quality care, and incorporate data beyond dual Medicare and Medicaid eligibility status to address disparities and account for the relationship between provider performance and community-level factors. These commenters also recommended reviewing the approaches of other CMS programs for potential adaptation in the SNF VBP Program, such as the proposed Transforming Episode Accountability Model's (TEAM) new beneficiary-economic risk adjustment factor included in the FY 2026 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System proposed rule (90 FR 18393). One commenter specifically encouraged the SNF VBP Program to account for differences in the providers' patient populations by considering an alternative scoring methodology with a peer-grouping-based design. A few commenters also recommended CMS advance a methodology that will result in a 70 percent payback percentage if the HEA is removed.

One commenter recommended that CMS provide guidance and training to SNFs on how to use SDOH information to improve care and outcomes before connecting health equity outcomes to reimbursement, such as providing reports with SDOH information through iQIES, CMS's designated system for distributing the SNF VBP Program's confidential feedback reports to SNFs, alongside targeting training.

One commenter suggested providing financial support through increased Medicaid payments to nursing homes would be more effective than the HEA.

Response: We thank the commenters for their support and recommendations. As we stated in the FY 2026 SNF PPS proposed rule (90 FR 18610), it will require time to develop and test an alternative, simplified structure for the HEA's bonus methodology. If pursued, we will review and consider adjustments adopted in other CMS quality programs to enhance cross-program alignment whenever feasible and effective. In addition, if pursued, any new adjustment for the SNF VBP Program would be addressed in future rulemaking.

With respect to commenters' other recommendations for improving outcomes, we thank the commenters for their recommendations and will take them into consideration as part of our monitoring and evaluation efforts for the SNF VBP Program.

Comment: Many commenters did not support CMS' proposal to remove the HEA. These commenters noted that caring for vulnerable populations with more complex social and medical needs, such as dual eligible residents, often requires additional resources. These commenters stated their concerns that removal of the HEA could potentially disincentivize providers from serving those vulnerable and costly residents. These commenters also referenced various findings that show vulnerable populations, such as dual eligible residents, are more likely to face disparities in quality of care and worse outcomes across care settings, indicating there are opportunities for quality-of-care improvements which the HEA could help address. A few of these commenters also recommended that, if the HEA is removed, CMS consider alternative approaches to account for

the complex needs of vulnerable populations and to incentivize SNFs that care for these vulnerable populations, such as by implementing targeted quality measures to reduce disparities or increasing the payback percentage. One commenter recommended delaying the removal of the HEA until a revised methodology is shared for public comment and recommended also conducting a distributional analysis on the effects of the HEA removal on diverse populations. One commenter recommended keeping the HEA but renaming it to the ''Dual Eligible Adjustment'' so the intent of the adjustment is more accurately reflected.

One commenter noted that the HEA helps create a fairer system for safety net hospitals serving high numbers of vulnerable patients, and noted the HEA is aligned with the Hospital Readmission Reduction Program (HRRP).

A few commenters also stated the need to capture equity information to improve the quality of care and support the nursing population.

Response: We acknowledge the commenters' concerns and thank the commenters for their recommendations. With respect to the concerns that caring for dual eligible residents with more complex social and medical needs often requires additional resources and that removing the HEA could potentially disincentivize providing care to those vulnerable and costly residents, as we noted in the FY 2026 SNF PPS proposed rule (90 FR 18610), we intended for the HEA to appropriately recognize the resource intensity expended to achieve high performance on quality measures by SNFs that serve a high proportion of SNF residents with dual eligibility status. We also intended for the HEA to mitigate the worse health outcomes experienced by dually eligible residents through incentivizing better care across all SNFs. However, our analysis, as described previously and in the FY 2026 SNF PPS proposed rule (90 FR 18610), indicated the HEA did not meaningfully reward SNFs for achieving high performance on quality measures. The HEA increased the average incentive payment multiplier by an estimated 0.09 percent, signaling the HEA would only minimally increase an individual SNF's incentive payments, and thus we expect the HEA is not likely to meaningfully incentivize SNFs to admit dual eligible residents with more complex social and medical needs and achieve high performance on the Program's quality measures. Although we recognize there are opportunities for quality-of-care improvements for dually eligible residents, we do not expect the HEA to capitalize on these opportunities given its minimal estimated impact, and it will require time to develop and test a new adjustment for the SNF VBP Program which more fully addresses these concerns in a simplified approach. If pursued, a new adjustment would be addressed in future rulemaking.

Also, with respect to commenters' concern about the importance of data collection, as previously stated, the removal of the HEA would only simplify the SNF VBP Program's scoring methodology and would have no implications on CMS' data reporting requirements for SNFs.

Finally, with respect to the commenter's concern about misalignment with the HRRP, we note that although both the SNF VBP Program's HEA and the HRRP evaluate beneficiaries who are dually eligible for Medicare and full Medicaid benefits, the SNF VBP Program and HRRP use different methodologies. As directed by Section 15002 of the 21st Century Cures Act, the HRRP uses a peer grouping methodology that assesses hospitals' performance relative to that of other hospitals with a similar proportion of stays for dually eligible beneficiaries, while the SNF VBP Program's HEA does not use a peer grouping methodology.

After consideration of public comments, we are finalizing the removal of the HEA, and codifying this removal by removing §§ 413.338(k) and (e)(3)(iii) from our regulations, removing terms related to the HEA in § 413.338(a) of our regulations, and revising § 413.338(c)(2)(i) of our regulations to remove the variable payback percentage adopted beginning in the FY 2027 program year and instead maintain the 60 percent payback percentage adopted beginning in the FY 2023 program year, as proposed without modification.

C. SNF VBP Program Measures

1. Background

Our current measure selection, retention, and removal policy is codified at § 413.338(l) of our regulations. We also refer readers to the FY 2024 SNF PPS final rule for background on the measures we have adopted for the SNF VBP Program (88 FR 53276 through 53297). Table D14 lists the measures that have been adopted for the SNF VBP Program, along with their status in the program for the FY 2026 program year through the FY 2029 program year.

TABLE 14: SNF VBP Program Measures and Status in the SNF VBP Program for the FY 2026 Program Year Through the FY 2029 Program Year

Measure	FY 2026 Program Year	FY 2027 Program Year	FY 2028 Program Year	FY 2029 Program Year
Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Included	Included		
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (SNF HAI) measure	Included	Included	Included	Included
Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) measure	Included	Included	Included	Included
Total Nursing Staff Turnover (Nursing Staff Turnover) measure	Included	Included	Included	Included
Discharge to Community – Post-Acute Care Measure for Skilled Nursing Facilities (DTC PAC SNF)		Included	Included	Included
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury (Long-Stay)) measure		Included	Included	Included
Discharge Function Score for SNFs (DC Function) measure		Included	Included	Included
Number of Hospitalizations per 1,000 Long Stay Resident Days (Long Stay Hospitalization) measure		Included	Included	Included
Skilled Nursing Facility Within-Stay Potentially Preventable Readmissions (SNF WS PPR) measure			Included	Included

While we did not propose any changes to the previously adopted SNF VBP Program measure set, we received several comments on quality measurement topics. The following is a summary of the comments and our responses.

Comment: One commenter supported the current SNF VBP Program measure set. One commenter supported the current SNF VBP Program measure set, particularly the inclusion of the staffing-related measures, but recommended that CMS add a workforce equity measure to reward nursing homes for offering high quality jobs to historically undervalued staff. This commenter recommended first building a measure based on direct worker compensation, then in the future, building a measure evaluating the quality of health insurance benefits.

One commenter supported the Nursing Staff Turnover measure. One commenter recommended assessing the accuracy and effectiveness of the Nursing Staff Turnover measure and considering whether alternative measures may be more appropriate given the ongoing workforce challenges in the SNF sector. One commenter recommended changes to the Nursing Staff Turnover measure, specifically excluding nurses who were moved to another SNF within the same health system from the measure numerator. This commenter believed that flexible workforces allow for increased efficiency and improved quality of care and as a result the measure should not penalize the health systems that choose to implement this staffing method.

One commenter did not support the current SNF VBP Program measure set and recommended that CMS remove the SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, Falls with Major Injury (Long-Stay), and Long Stay Hospitalizations measures from the current measure set to simplify the Program and remove measures they consider duplicative and/or not aligned with Medicare Part A reimbursement. However, this commenter did support use of the SNF WS PPR measure rather than the SNFRM. One commenter did not comment directly on the current SNF VBP Program measure set but recommended CMS establish clearer expectations for registered dietitian nutritionist (RDN) staffing, either through facility assessment requirements, quality improvement programs, or relevant payment and reporting mechanisms, to promote more consistent access to medically necessary nutrition care.

Response: We thank the commenters for their support and recommendations, as well as acknowledge their concerns. We intend to take this feedback into consideration as part of our monitoring and evaluation efforts related to the SNF VBP Program measure set.

D. SNF VBP Performance Standards

1. Background

Our current definitions for the performance standards are codified at § 413.338(a), and our current performance standards notification and updates policies are codified at § 413.338(n). We also refer readers to the FY 2024 SNF PPS final rule (88 FR 53299 through 53300) for a detailed history of our performance standards policies. In the FY 2025 SNF PPS final rule (89 FR 64128 through 64129), we adopted the final numerical values for the FY 2027 performance standards and the final numerical values for the FY 2028 performance standards for the Discharge to Community—Post-Acute Care Measure for Skilled Nursing Facilities (DTC PAC SNF) and Skilled Nursing Facility Within-Stay Potentially Preventable Readmissions (SNF WS PPR) measures.

2. Performance Standards for the FY 2028 Program Year

To meet the requirements at section 1888(h)(3)(C) of the Act, we are

providing the final numerical performance standards for the remaining measures applicable for the FY 2028 program year: the SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI) measure, Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) measure, Total Nursing Staff Turnover (Nursing Staff Turnover) measure, Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury (Long-Stay)) measure, Number of Hospitalizations per 1,000 Long Stay Resident Days (Long Stay Hospitalization) measure, and Discharge Function Score for SNFs (DC Function) measure. In accordance with our methodology for calculating performance standards previously finalized in the FY 2017 SNF PPS final rule (81 FR 51996 through 51998), the final numerical values for the FY 2028 program year performance standards are shown in Table 15. These final values are only minorly different from the estimated values included in the FY 2026 SNF PPS proposed rule (90 FR 18611).

TABLE 15: FY 2028 SNF VBP Program Performance Standards

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

3. Performance Standards for the FY 2029 Program Year

To meet the requirements at section 1888(h)(3)(C) of the Act, we are providing the final numerical performance standards for the FY 2029 program year for the DTC PAC SNF and SNF WS PPR measures. In accordance with our methodology for calculating performance standards previously finalized in the FY 2017 SNF PPS final rule (81 FR 51996 through 51998), the final numerical values for the FY 2029 program year performance standards for the DTC PAC SNF and SNF WS PPR measures are shown in Table 16. These final values are only minorly different from the estimated values included in the FY 2026 SNF PPS proposed rule (90 FR 18612).

We will provide the estimated numerical performance standards values for the remaining measures applicable to the FY 2029 program year in the FY 2027 SNF PPS proposed rule.

TABLE 16: FY 2029 SNF VBP Program Performance Standards

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

E. SNF VBP Performance Scoring Methodology

1. Application of SNF VBP Scoring Methodology to the SNF WS PPR Measure

a. Background

Our scoring methodology beginning in the FY 2027 program year is codified at §§ 413.338(e)(1) and 413.338(e)(3), and our current case minimum and measure minimum policies are at § 413.338(b). We also refer readers to the FY 2024 SNF PPS final rule (88 FR 53300 through 53304) for a detailed history of our performance scoring methodology, the FY 2025 SNF PPS final rule (89 FR 64131 through 64132) for an update to the measure minimum policy for the FY 2028 program year and subsequent program years, and to section VII.B. of this final rule where we are finalizing removal of the Health Equity Adjustment (HEA) previously finalized in the FY 2024 SNF PPS final rule (88 FR 53304 through 53318). Under this methodology, we will calculate the SNF performance score beginning with the FY 2027 program year as follows:

- Award up to 10 points for each measure based on improvement or achievement, so long as the SNF reports a measure's applicable minimum number of cases during the performance period applicable to that fiscal year; and
- Sum all points awarded to a SNF based on their performance on each measure; we will normalize the SNF's point total such that the resulting point total is expressed as a number of points earned out of a total of 100.

In the FY 2023 SNF PPS final rule (87 FR 47588 through 47590), we finalized an application of the scoring methodology to the SNF HAI, DTC PAC SNF, and Total Nurse Staffing measures. In the FY 2024 SNF PPS final rule (88 FR 53303 through 53304), we finalized an application of the scoring methodology to the Nursing Staff Turnover, Falls with Major Injury (Long-Stay), Long Stay Hospitalization, and DC Function measures. Lastly, in the FY 2024 SNF PPS final rule (88 FR 53303), we stated that we intended to address the FY 2028 performance scoring methodology in future rulemaking, as we had also finalized our proposal to replace the SNFRM with the SNF WS PPR measure beginning with the FY 2028 program year.

b. Application of the SNF VBP Scoring Methodology to the SNF WS PPR Measure Beginning With the FY 2028 Program Year

In the FY 2024 SNF PPS final rule (88 FR 53280), we finalized that the SNF WS PPR measure will replace the SNFRM beginning with the FY 2028

SNF VBP program year. In the FY 2026 SNF PPS proposed rule (90 FR 18612), we proposed applying the previously finalized scoring methodology codified at §§ 413.338(e)(1) and 413.338(e)(3) to the SNF WS PPR measure beginning with the FY 2028 program year to align the scoring methodology applied to the SNF WS PPR measure with the scoring methodology previously finalized and applied to all other measures in the SNF VBP Program's measure set.

We invited and received public comments on our proposal to apply the previously finalized scoring methodology to the SNF WS PPR measure beginning with the FY 2028 SNF VBP program year. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported the application of the previously finalized scoring methodology to the SNF WS PPR measure beginning with the FY 2028 SNF VBP program year. Two commenters confirmed their continued support for adopting and implementing the SNF WS PPR measure. One of those two commenters also supported the current scoring methodology's normalization policy, while the other commenter supported the scoring methodology's consideration of both current performance and improvement.

Response: We thank the commenters for their support. We agree that the application of the previously finalized scoring methodology to the SNF WS PPR measure will align all the measures within the SNF VBP Program's measure set.

Comment: One commenter supported the application of the previously finalized scoring methodology to the SNF WS PPR measure but encouraged CMS to consider the effect of applying the existing SNF VBP Program scoring methodology to the SNF WS PPR measure on low-volume rural SNFs. The commenter highlighted evidence of measures without risk adjustment disadvantaging rural SNFs.

Response: We thank the commenter for their support and acknowledge their concern. However, the SNF WS PPR measure includes a hierarchical logistic regression risk adjustment model, and historical results for the SNF WS PPR measure indicate marginally better performance for rural SNFs compared to urban SNFs. Additionally, the 2-year data period used by the SNF WS PPR measure increases reportability for low-volume SNFs. We intend to continue assessing these concerns as part of our monitoring and evaluation efforts.

Comment: One commenter recommended that CMS not invert measure scores for certain measures where a lower score is preferable, as it causes confusion and complexity. One commenter recommended that CMS consider developing more targeted incentives, such as bonus points within the SNF VBP Program for SNFs operating within Tribally operated long-term care facilities to recognize their vital role providing high quality care within (frequently rural and remote) Tribal communities.

Response: We thank the commenters for their recommendations. With respect to the commenter's recommendation not to invert measure scores for certain measures where a lower score is preferable, we note that measure results are not inverted within confidential feedback reports or publicly reported datasets to support understanding by SNFs and other interested parties. Measure results are only inverted for purposes of achievement scoring and improvement scoring so that higher scores indicate better performance for all measures.

After consideration of public comments, we are finalizing the application of the previously finalized scoring methodology (codified at § 413.338(e)(1) and § 413.338(e)(3)) to the SNF WS PPR measure beginning with the FY 2028 SNF VBP program year as proposed without modification.

F. Adopting a SNF VBP Program Reconsideration Request Process

1. Background

We refer readers to the FY 2025 SNF PPS final rule (89 FR 64133 through 64136) and to § 413.338(f) for details on the SNF VBP Program's confidential feedback reports policies, the two-phase review and correction process, and public reporting policies that we have adopted for the Program. We also refer readers to the SNF VBP Program website (*https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/confidential-feedback-reporting-review-and-corrections*) for technical details on our review and correction process.

In Phase One of the review and correction process, codified at § 413.338(f)(2), we accept correction requests for 30 days after distributing the baseline period and performance period quality measure quarterly reports, which contain the baseline period and performance period measure results, respectively. SNFs may submit corrections to the measure results contained in those reports. The underlying data used to calculate the measure results are not subject to review and correction during this process. As provided in § 413.338(f)(1), measure results included in those reports are calculated using data current as of specified dates for each measure.

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

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

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

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

In the FY 2026 SNF PPS proposed rule (90 FR 18612), we proposed adopting a reconsideration request process that would allow SNFs to seek reconsideration of a review and correction request if they are not satisfied with our decision on a review and correction request submitted under §§ 413.338(f)(2) or (f)(3). We also proposed related technical updates to our regulations to align the submission requirements for the reconsideration request process with the submission requirements under the review and correction process.

2. SNF VBP Program Reconsideration Request Process

Beginning with the FY 2027 SNF VBP program year, we proposed to adopt and implement a reconsideration request process that would be an additional appeal process available to SNFs beyond the existing Phase One and Phase Two review and correction process. The reconsideration request process would align the SNF VBP Program with other CMS quality programs, including the Expanded Home Health Value-Based Purchasing

(HHVBP) Model (42 CFR 484.375(b)), to create a familiar policy experience for providers across CMS quality programs.

As stated in FY 2026 SNF PPS proposed rule (90 FR 18612), SNFs would be able to request this additional reconsideration only if they first submitted a valid review and correction request described at §§ 413.338(f)(2) or (3) and are dissatisfied with the decision.

Under the proposed reconsideration request process, SNFs would have 15 calendar days to submit a reconsideration request, starting the day after the date we issue a decision via email on a review and correction request (as noted on that decision) submitted under section §§ 413.338(f)(2) or (3). SNFs that seek reconsideration of a review and correction request decision would have to submit their reconsideration requests via email in the form and manner specified by CMS in the review and correction decision. The reconsideration request would have to contain all of the following:

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

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

We also proposed to codify the proposed SNF VBP Program reconsideration request process at § 413.338(f)(6).

We invited and received public comment on our proposal to adopt and implement a reconsideration request process that would be an additional appeal process available to SNFs beyond the existing Phase One and Phase Two review and correction process, and our proposal to codify such process at § 413.338(f)(6). The following is a summary of the comments we received and our responses.

Comment: Many commenters supported CMS' proposal to adopt a reconsideration request process for the SNF VBP Program. A few commenters believed the adoption of the reconsideration request process would result in more transparent and fair practices. A few commenters appreciated CMS aligning processes in the SNF VBP Program with those processes in other CMS quality programs. One commenter appreciated CMS' utilization of electronic communications for facilitating the reconsideration request process. One commenter believed that the reconsideration request process would help resolve potential misunderstandings between SNFs and CMS and result in more accurate publicly available data.

Response: We thank the commenters for their support. We agree that the adoption of the reconsideration request process will better align the SNF VBP Program with other CMS quality programs and create a more transparent and accurate reporting process.

Comment: A few commenters supported adopting the reconsideration request process but provided additional recommendations. One commenter recommended increasing the submission timeframe from 15 calendar days to 30 or even 60 calendar days to allow a SNF adequate time to review, gather, and submit any applicable documentation to support the reconsideration request. One commenter supported the 15-day submission timeframe but noted the ability to request reconsideration may influence a SNF's approach to quality measurement and performance under the SNF VBP Program. One commenter recommended informing SNFs of reconsideration request decisions before data is publicly reported. One commenter encouraged CMS to consider implementing similar appeal processes in other programs.

Response: We thank the commenters for their recommendations. With respect to the commenter's recommendation around increasing the submission timeframe, we believe the current timeframe of 15 calendar days is sufficient for SNFs to review CMS' decision and acquire and submit any additional documentation necessary to the reconsideration request, as any reconsideration request would pertain to the initial review and correction request previously submitted under section § 413.338(f)(2) or (3) by the SNF. We also believe an extension of the reconsideration request timeframe would result in undesired delays in publicly reporting SNF VBP Program data.

With respect to the commenter's suggestion that the reconsideration request process could affect a SNF's approach to quality measurement and performance under the SNF VBP Program, we note the existing review and correction process at §§ 413.338(f)(2) and (3) requires SNFs to identify the error for which it is requesting correction and explain its reason for requesting the correction. We will review all review and correction requests, as well as all reconsideration requests, and only accept the request if deemed valid, that is, if an error in the calculations of the measures results, performance scores, or rankings is correctly identified and should be corrected before any affected data becomes publicly available.

With respect to the commenter's recommendation to inform SNFs of the reconsideration request decisions before data is publicly reported, the proposed reconsideration request process would provide a written decision to the SNF in a timely manner before any affected data becomes publicly available.

With respect to commenters' recommendation to consider implementing similar appeal processes in other programs, we thank the commenters for their recommendation and will take this into consideration as part of our monitoring and evaluation efforts.

Comment: One commenter did not support the proposal to adopt the reconsideration request process as they believed the SNF VBP Program already provided an opportunity for SNFs to review data regarding their performance and providing additional opportunities would weaken enforcement of CMS standards.

Response: We acknowledge the commenter's concern, but we disagree that this reconsideration request process would weaken the enforcement of CMS standards. While the existing review and correction process does provide SNFs an opportunity to review data regarding their performance, we believe it is important to provide the proposed reconsideration request process to align the SNF VBP Program with other CMS quality programs to create a familiar policy experience for providers across CMS quality programs. Also, all reconsideration requests would be thoroughly and efficiently reviewed to confirm only valid requests are accepted and to avoid undesired delays in publicly reporting SNF VBP Program data.

After consideration of public comments, we are finalizing the adoption and implementation of the reconsideration request process, and codifying this process at § 413.338(f)(6), as proposed without modification.

3. Regulation Text Technical Updates

In the FY 2026 SNF PPS proposed rule (90 FR 18613), we proposed

codifying certain provisions of our existing review and correction process that we finalized in the FY 2017 SNF PPS final rule (81 FR 52006 through 52009) and in the FY 2018 SNF PPS final rule (82 FR 36621 through 36623) but did not codify at that time. Specifically, we proposed updating §§ 413.338(f)(2) and (3) to specify that SNFs must submit their review and correction requests by sending an email to the SNF VBP Program Help Desk, which is currently available at *SNFVBPquestions@cms.hhs.gov.*

We invited public comment on these proposed technical updates to our regulations text.

We did not receive public comments on these proposals.

We are finalizing these proposed updates to our regulation text at §§ 413.338(f)(2) and (3) as proposed without modification.

VIII. Collection of Information Requirements

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

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

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

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

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

As stated in section VI.C. of this final rule, we are finalizing our proposal to remove four standardized patient assessment data elements under the SDOH category beginning with the FY 2027 SNF QRP. In section VI.D. of this final rule, we are also finalizing our proposal to amend our reconsideration policy and process. As we noted in the FY 2016 SNF PPS proposed rule (80 FR 22082), because the reconsideration requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the PRA. We have, however, provided detailed burden estimates in sections IX.A.6.a. and IX A.6.b. of this final rule.

1. ICRs Regarding the Removal of Four Standardized Patient Assessment Data Elements Beginning With the FY 2027 SNF QRP

As stated in section VI.C. of the proposed rule, we proposed to remove four standardized patient assessment data elements under the SDOH category previously adopted for collection and submission on admission using the MDS beginning October 1, 2025. The MDS, in its current form, has been approved under OMB control number 0938–1140. On November 25, 2024, under the PRA, we placed a notice in the **Federal Register** (89 FR 92939, November 25, 2024) on the revised collection and implementation of the MDS 3.0 v1.20.1 beginning October 1, 2025. Although we did not receive any comments in response to this notice, the revised collection and implementation package was not finalized. We are now revising the package to support the removal of four standardized patient assessment data elements under the SDOH category previously adopted and seeking comment on the updated package.

The net result of removing four data elements at admission is an estimated decrease of 1.2 minutes or 0.02 hour of clinical staff time at admission (4 data elements × 0.005 hour). We identified the staff type based on past SNF burden calculations, and our assumptions were based on the categories generally necessary to perform an assessment. We believe these items would be completed equally by a Registered Nurse (RN) and Licensed Practical and Licensed Vocational Nurse (LPN/LVN). However, individual SNFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wage estimates for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates.[11] To account for other indirect costs and fringe benefits, we doubled the median hourly wage. These amounts are detailed in Table 17. We established a composite cost estimate using our adjusted hourly wage estimates. The composite estimate of $70.10/hr was calculated by weighting the adjusted hourly wage of the RN and LPN/LVN equally [($82.76/hr × 0.5) plus ($57.44/hr × 0.5) = $70.10].

TABLE 17: U.S. Bureau of Labor and Statistics' May 2023 National Occupational Employment and Wage Estimates

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

[11] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. May 2023. *https://www.bls.gov/oes/current/oes_stru.htm.*

We estimate that the burden and cost for SNFs for complying with the requirements of the FY 2027 SNF QRP would decrease under this update. Using FY 2024 data, we estimate a total of 1,589,560 5-day PPS assessments by 15,253 SNFs for an annual decrease of 31,791.20 hours in burden for all SNFs at admission (1,589,560 5-day PPS assessments × 0.02 hour) and an annual decrease of 2.08 hours in burden per SNF at admission (31,791.20 hours/15,253 SNFs). Given 0.02 hour at $70.10 per hour to complete an average of 104 5-day PPS assessments per SNF per year, we estimate the total annual cost at admission would be decreased by $2,228,563.12 for all SNFs (31,791.20 hours x $70.10/hr) or $146.11 per SNF ($2,228,563.12/15,253 SNFs).

The total estimated burden associated with the removal of four standardized patient assessment data elements at admission (as described in this section) is summarized in Table 18.

TABLE 18: Estimated Reduction in Burden Associated with Removal of Four Standardized Patient Assessment Data Elements Under the SDOH Category Beginning with the FY 2027 SNF QRP

Requirement	Per SNF		All SNFs	
	Change in annual burden hours	Change in annual cost	Change in annual burden hours	Change in annual cost
Removal of Four Standardized Patient Assessment Data Elements	-2.08	-$146.11	-31,791.20	-$2,228,563.12

We solicited public comments on the proposed information collection requirements and whether our estimated burden reduction of 0.02 hours per patient and an annual decrease of 2.08 hours in burden per SNF at admission is an accurate estimate. We have summarized the comments we received about burden in section VI.C. of this final rule and provided responses. We did not receive any comments about whether our estimated burden is an accurate estimate. After careful consideration of the public comments we received, we are finalizing our proposal to remove four standardized patient assessment data elements under the SDOH category.

B. ICRs Regarding the Skilled Nursing Facility Value-Based Purchasing Program

With regard to the SNF VBP Program, we are not adding, modifying, or removing any collection of information requirements or burden related to the SNF VBP Program in this final rule. Consequently, this final rule does not set out any new SNF VBP Program-related collections of information that would be subject to OMB approval under the authority of the PRA. For the purpose of this section, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

We did not propose any new or modified information collection requirements, thus we did not solicit any public comments. We also did not receive any public comments on the existing information collection requirements for the SNF VBP Program.

IX. Regulatory Impact Analysis

A. Statement of Need

1. Statutory Provisions

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

With respect to the SNF QRP, under the statutory discretion afforded to the Secretary under section 1886(e)(6) of the Act, we are updating requirements. As described in section VI.C. of the final rule, we are removing four standardized patient assessment data elements beginning with the FY 2027 SNF QRP. As described in VI.D. of this final rule, we are also updating our reconsideration policy and process.

With respect to the SNF VBP Program, we are updating the SNF VBP Program requirements for FY 2026 and subsequent years. As described in section VII. of this final rule, we are removing the Health Equity Adjustment from the Program's scoring methodology, applying the Program's scoring methodology to the Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure, and adopting a new reconsideration process that will allow SNFs to appeal CMS decisions on review and correction requests. In addition, Section 1888(h)(3) of the Act requires the Secretary to establish and announce performance standards for SNF VBP Program measures no later than 60 days before the beginning of the performance period, and this final rule provides final numerical values of the performance standards for the FY 2028 program year for the SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization measures; and final numerical values of the performance standards for the FY 2029 program year for the DTC PAC SNF and SNF WS PPR measures.

2. Discretionary Provisions

In addition, this final rule includes the following discretionary provisions:

a. SNF Forecast Error Adjustment

Each year, we evaluate the SNF market basket forecast error for the most recent year for which historical data is available. The forecast error is determined by comparing the projected SNF market basket increase each year with the actual SNF market basket increase in that year. In evaluating the data for FY 2024, we found that the

forecast error for that year was 0.6 percentage point, exceeding the 0.5 percentage point threshold we established in regulation to trigger a forecast error adjustment. Given that the forecast error exceeds the 0.5 percentage point threshold for FY 2024, current regulations require that the SNF market basket percentage increase for FY 2026 be adjusted upward by 0.6 percentage point to account for forecasting error in the FY 2024 SNF market basket update.

b. Technical Updates to ICD–10 Mappings

In the FY 2019 SNF PPS final rule (83 FR 39162), we finalized the implementation of the PDPM, effective October 1, 2019. The PDPM utilizes ICD–10 codes in several ways, including using the patient's primary diagnosis to assign patients to clinical categories under several PDPM components, specifically the PT, OT, SLP and NTA components. In this rule, we are making several substantive changes to the PDPM ICD–10 code mapping.

3. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 801–808).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities. A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. Based on our estimates, the Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs (OIRA) has determined this rulemaking is significant per section 3(f)(1). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of the rulemaking.

4. Overall Impacts

This rule updates the SNF PPS rates contained in the FY 2025 SNF PPS final rule (89 FR 64048). We estimate that the aggregate impact will be an increase of approximately $1.16 billion (3.2 percent) in Part A payments to SNFs in FY 2026. As we noted in the proposed rule, these impact numbers do not incorporate the SNF VBP Program reductions that we estimate will total $208.36 million in FY 2026. We note that events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented, and thus, very susceptible to forecasting errors due to events that may occur within the assessed impact time period.

In accordance with sections 1888(e)(4)(E) and (e)(5) of the Act and implementing regulations at § 413.337(d), we are updating the FY 2025 payment rates by a factor equal to the market basket percentage increase adjusted for the forecast error adjustment and reduced by the productivity adjustment to determine the payment rates for FY 2026. The impact to Medicare is included in the total column of Table 19. The annual update in this rule applies to SNF PPS payments in FY 2026. Accordingly, the analysis of the impact of the annual update that follows only describes the impact of this single year. Furthermore, in accordance with the requirements of the Act, we will publish a rule or notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

5. Detailed Economic Analysis

The FY 2026 SNF PPS payment impacts appear in Table 19. Using the most recently available claims data, in this case FY 2024, we apply the current FY 2025 case-mix indices (CMIs), wage index and labor-related share value to the number of payment days to simulate FY 2025 payments. Then, using the same FY 2024 claims data, we apply the FY 2026 CMIs, wage index and labor-related share value to simulate FY 2026 payments. We tabulate the resulting payments according to the classifications in Table 19 (for example, facility type, geographic region, facility ownership), and compare the simulated FY 2025 payments to the simulated FY 2026 payments to determine the overall impact. The breakdown of the various categories of data in Table 19 is as follows:

- The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, census region, and ownership.
- The first row of figures describes the estimated effects of the various changes contained in this final rule on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The next nineteen rows show the effects on facilities by urban versus rural status by census region. The last three rows show the effects on facilities by ownership (that is, government, profit, and non-profit status).
- The second column shows the number of facilities in the impact database.
- The third column shows the effect of the annual update to the wage index, including the updates to the labor related-share discussed in section III.D. of this final rule. This represents the effect of using the most recent wage data available as well as accounts for the 5 percent cap on wage index decreases. The total impact of this change is 0.0 percent; however, there are distributional effects of the change.
- The fourth column shows the net (total) effect of all of the changes on the FY 2026 payments. This column reflects the overall 3.2 percent update applicable to all providers plus or minus the wage index adjustment in column 3. It is projected that aggregate payments will increase by 3.2 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 19, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes in this rule, rural providers will experience a 3.7 percent increase in FY 2026 total payments.

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TABLE 19: Impact to the SNF PPS for FY 2026

Impact Categories	Number of Facilities	Update Wage Data	Total Change
Group			
Total	15,288	0.0%	3.2%
Urban	11,079	-0.1%	3.1%
Rural	4,209	0.5%	3.7%
Hospital-based urban	329	-0.3%	2.9%
Freestanding urban	10,750	-0.1%	3.1%
Hospital-based rural	351	0.7%	3.9%
Freestanding rural	3,858	0.5%	3.7%
Urban by region			
New England	694	1.6%	4.9%
Middle Atlantic	1,430	-0.4%	2.8%
South Atlantic	1,895	0.3%	3.6%
East North Central	2,168	0.6%	3.8%
East South Central	560	0.6%	3.9%
West North Central	925	1.1%	4.4%
West South Central	1,460	-0.5%	2.7%
Mountain	532	0.2%	3.4%
Pacific	1,410	-1.2%	2.0%
Outlying	5	0.3%	3.5%
Rural by region			
New England	121	-0.3%	2.8%
Middle Atlantic	222	0.2%	3.5%
South Atlantic	523	0.4%	3.6%
East North Central	883	1.2%	4.4%
East South Central	471	-0.9%	2.3%
West North Central	975	0.3%	3.5%
West South Central	729	0.2%	3.4%
Mountain	195	3.3%	6.6%
Pacific	89	1.1%	4.4%
Outlying	1	0.2%	3.4%
Ownership			
For -profit	10,930	-0.1%	3.1%
Non-profit	3,318	0.4%	3.6%
Government	1,040	0.2%	3.4%

Note: The Total column includes the FY 2026 SNF market basket update of 3.2 percent. The values presented in Table F19 may not sum due to rounding.

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6. Impacts for the Skilled Nursing Facility Quality Reporting Program (SNF QRP) for FY 2027 SNF QRP

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

a. Impacts for Removing the Collection and Submission Requirements of Four Standardized Patient Assessment Data Elements Beginning With the FY 2027 SNF QRP

As discussed in section VI.C. of this final rule, we are finalizing our proposal to remove four standardized patient assessment data elements under the SDOH category beginning with residents admitted on October 1, 2025, for the FY 2027 SNF QRP. We are providing estimated impact information as reflected in Table 20.

As discussed in section VIII.A.1. of this final rule, we estimated the net result of removing four data elements at admission would decrease burden. As finalized, SNFs will not be required to collect and submit four standardized patient assessment data elements beginning with residents admitted on or after October 1, 2025 as previously finalized. Using FY 2024 data, we estimate an annual total of 1,589,560 5-day PPS assessments by 15,253 SNFs for an annual decrease of 31,791.20 hours (1,589,560 5-day PPS assessments × 0.02 hour) and an annual decrease in cost of $2,228,563.12 (31,791.20 hours x $70.10/hr) for all SNFs at admission. For each SNF, we estimate an annual burden decrease of 2.08 hours (31,791.20 hours/15,253 SNFs) and an

annual decrease in cost of $146.11 ($2,228,563.12/15,253 SNFs) at admission.

b. Impacts for Amending the Reconsiderations Request Policy and Process

As discussed in section VI.D. of this final rule, we are finalizing our proposal to amend the SNF QRP reconsiderations request policy and process. As we noted in the FY 2016 SNF PPS Proposed rule (80 FR 22082) and in section VIII.A.1. of this final rule, because the reconsideration requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the PRA however, we are providing full estimated impact information.

The updates to this policy and process will result in a collection of information intended to be submitted only by SNFs if they seek to file an extension to file a request for reconsideration of a noncompliance determination. We estimate that this information will take SNFs approximately 15 minutes to complete. We believe this data will be entered by a Medical Records Specialist. However, individual SNFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages from the U.S. Bureau of Labor Statistics' (BLS) May 2023 National Occupational Employment and Wage Estimates. To account for overhead and fringe benefits, we have doubled the median hourly wage as detailed in Table 20.

TABLE 20: U.S. Bureau of Labor and Statistics' May 2023 National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Median Hourly Wage ($/hr)	Other Indirect Costs and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Medical Records Specialists	29-2072	$23.45	$23.45	$46.90

Historically, less than 2 percent of SNFs submit a reconsideration request annually. Based on the number of reconsiderations requests received over the previous 3 years, we estimate an average of 202 SNFs submit a reconsideration request annually. We estimate that, if all 202 SNFs sought to file an extension to file a request for reconsideration, the burden and cost for these SNFs will increase under this update. We estimate that it will take 15 minutes (0.25 hour) to complete and submit the data for an annual increase of 51 hours in burden for all 202 estimated SNFs submitting these requests (15 minutes × 202 SNFs). Given 51 hours at $46.90 per hour to complete an average of 202 entries among these SNFs annually, we estimate the total annual cost will be an increase by $2,391.90 for all SNFs (51 hours × $46.90/hr) and $11.84 per SNF (0.25 hours × $46.90/hr).

The total estimated burden associated with amending the reconsiderations request policy and process (as described in this section) is summarized in Table 21.

TABLE 21: Estimated Increase in Burden Associated with Amending the Reconsiderations Request Policy and Process

Requirement	Per SNF		All SNFs (n=202)	
	Change in annual burden hours	Change in annual cost	Change in annual burden hours	Change in annual cost
Proposal to Amend the Reconsiderations Request Policy and Process	+0.25	+$11.84	+51	+$2,391.90

We requested public comments on the overall impact of the SNF QRP proposals for FY 2027 displayed in Table 22.

We did not receive any comments about the impact of the SNF QRP proposals.

TABLE 22: Estimated Impacts for the FY 2027 SNF QRP

Estimated Impacts for the FY2027 SNF QRP	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden Associated with Removal of Four Standardized Patient Assessment Data Elements at Admission Beginning with the FY 2027 SNF QRP	-2.08	-$146.11	-31,791.20	-$2,228,563.12
Estimated Change in Burden Associated with Amending the Reconsiderations Request Policy and Process for those SNF's requesting an extension to file a request for reconsideration	+0.25	+$11.84	+51	+$2,391.90

7. Impacts for the SNF VBP Program

The estimated impacts of the FY 2026 SNF VBP Program are based on historical data and appear in Table 23 and Table 24. We modeled SNF performance in the Program using SNFRM, SNF HAI, Total Nurse Staffing, and Nursing Staff Turnover measure results from FY 2022 as the baseline period and FY 2023 as the performance period. Additionally, we modeled a logistic exchange function with a payback percentage of 60 percent, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36619 through 36621).

For the FY 2026 program year, we will reduce each SNF's adjusted Federal per diem rate by 2 percent. We will then redistribute 60 percent of that 2 percent withhold to SNFs based on their measure performance. Additionally, in the FY 2023 SNF PPS final rule (87 FR 47585 through 47587), we finalized a case minimum requirement for the SNFRM, Total Nurse Staffing, and SNF HAI measures, and in the FY 2024 SNF PPS final rule (88 FR 53301 through 53302) we finalized a case minimum requirement for the Nursing Staff Turnover measure, as required by section 1888(h)(1)(C)(i) of the Act. Furthermore, in the FY 2023 SNF PPS final rule (87 FR 47587), we finalized the measure minimum requirement for the FY 2026 SNF VBP program year, as required by section 1888(h)(1)(C)(ii) of the Act. As a result of these provisions, SNFs must meet the case minimum for at least two of the four measures during the applicable performance period to receive a SNF performance score and value-based incentive payment for FY 2026; SNFs that do not meet the measure minimum requirement finalized for the FY 2026 program year will be excluded from the Program and will receive their adjusted Federal per diem rate for that FY. As previously finalized, this policy will maintain the overall payback percentage at 60 percent for the FY 2026 program year. Based on the 60 percent payback percentage, we estimated that we will redistribute approximately $312.53 million (of the estimated $520.89 million in withheld funds) in value-based incentive payments to SNFs in FY 2026, which means that the SNF VBP Program is estimated to result in approximately $208.36 million in savings to the Medicare Program in FY 2026.

Our detailed analysis of the impacts of the FY 2026 SNF VBP Program is shown in Table 23 and Table 24.

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TABLE 23: Estimated SNF VBP Program Impacts for FY 2026

Characteristic	Number of facilities	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean Total Nursing Hours per Resident Day (Total Nurse Staffing)	Mean Risk-Standardized Rate of Healthcare-Associated Infections (SNF HAI) (%)	Mean Total Nursing Staff Turnover Rate (Nursing Staff Turnover) (%)
Group					
Total*	13,859	20.30	3.80	7.16	49.76
Urban	10,208	20.37	3.79	7.17	50.05
Rural	3,651	20.08	3.81	7.10	48.92
Hospital-based urban**	217	20.08	4.89	6.38	41.21
Freestanding urban**	9,983	20.38	3.77	7.19	50.23
Hospital-based rural**	137	19.59	5.00	6.54	41.55
Freestanding rural**	3,465	20.09	3.76	7.14	49.20
Urban by region					
New England	673	20.55	3.93	6.86	44.55
Middle Atlantic	1,394	20.17	3.69	7.14	44.81
South Atlantic	1,819	20.48	3.84	7.32	49.89
East North Central	1,933	20.59	3.40	7.07	52.71
East South Central	511	20.54	3.94	7.26	52.17
West North Central	821	20.12	4.14	6.82	55.56
West South Central	1,221	20.80	3.59	7.37	55.87
Mountain	500	19.78	3.87	6.75	53.68
Pacific	1,333	19.97	4.23	7.49	43.92
Outlying	3	20.81	3.42	7.18	38.55
Rural by region					
New England	99	19.66	4.09	6.69	51.90
Middle Atlantic	185	19.68	3.54	6.93	47.47
South Atlantic	442	20.31	3.71	7.34	49.46
East North Central	810	20.11	3.46	7.00	47.36
East South Central	452	20.22	3.94	7.32	45.98
West North Central	816	19.89	4.09	6.95	49.57
West South Central	585	20.53	3.78	7.40	49.89
Mountain	179	19.59	4.00	6.70	55.60
Pacific	82	18.80	4.32	6.63	48.64
Outlying	1	19.02	7.46	6.30	N/A
Ownership					
Government	783	20.07	4.16	6.96	45.62
Profit	10,227	20.41	3.61	7.31	51.12
Non-Profit	2,849	19.96	4.38	6.63	45.84

* The total group category excludes 965 SNFs that failed to meet the finalized measure minimum requirement.

** The group category that includes hospital-based/freestanding by urban/rural excludes 57 swing bed SNFs that satisfied the finalized measure minimum requirement.

N/A = Not available because no facilities in this group received a measure result.

TABLE 24: Estimated SNF VBP Program Impacts for FY 2026

Characteristic	Number of facilities	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Group				
Total*	13,859	33.4046	0.99204	100.00
Urban	10,208	32.8795	0.99171	85.97
Rural	3,651	34.8730	0.99297	14.03
Hospital-based urban**	217	49.3566	1.00355	1.44
Freestanding urban**	9,983	32.5094	0.99145	84.51
Hospital-based rural**	137	54.7305	1.00720	0.30
Freestanding rural**	3,465	33.8471	0.99224	13.63
Urban by region				
New England	673	37.5977	0.99429	5.36
Middle Atlantic	1,394	35.9110	0.99351	19.07
South Atlantic	1,819	32.2951	0.99112	16.41
East North Central	1,933	27.5911	0.98852	11.05
East South Central	511	32.1759	0.99093	2.88
West North Central	821	35.0699	0.99368	3.68
West South Central	1,221	25.1047	0.98695	6.84
Mountain	500	34.9349	0.99322	3.65
Pacific	1,333	41.0703	0.99686	17.02
Outlying	3	30.2542	0.98736	0.00
Rural by region				
New England	99	41.1458	0.99733	0.53
Middle Atlantic	185	35.5071	0.99350	0.93
South Atlantic	442	31.3211	0.99047	2.00
East North Central	810	32.1198	0.99123	3.19
East South Central	452	36.5407	0.99349	1.87
West North Central	816	38.4286	0.99566	1.94
West South Central	585	31.4008	0.99047	2.25
Mountain	179	37.0521	0.99431	0.62
Pacific	82	47.4021	1.00229	0.70
Outlying	1	55.1034	1.01017	0.00
Ownership				
Government	783	41.8011	0.99799	3.22
Profit	10,227	29.7630	0.98946	80.87
Non-Profit	2,849	44.1691	0.99969	15.92

* The total group category excludes 965 SNFs that failed to meet the finalized measure minimum requirement. The total group category includes 95 SNFs that did not have historical payment data used for this analysis.

** The group category that includes hospital-based/freestanding by urban/rural excludes 57 swing bed SNFs that satisfied the measure minimum requirement.

N/A = Not available because no facilities in this group met the finalized measure minimum requirement.

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In section VII.B. of this final rule, we are finalizing our proposal to remove the Health Equity Adjustment (HEA) and the variable payback percentage that would account for the application of the HEA. Therefore, we are providing estimated impacts of the FY 2027 SNF VBP Program, which are based on historical data and appear in Tables 25, 26, and 27. We modeled SNF performance in the Program using SNFRM, SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, and DC Function measure results from FY 2022 as the baseline period and FY 2023 as the performance period, using Falls with Major Injury (Long-Stay) and Long Stay Hospitalization measure results from CY 2022 as the baseline period and FY 2023 as the performance period, and using DTC PAC SNF measure results from FY 2020 to 2021 as the baseline period and FY 2022 to 2023 as the performance period. Additionally, we modeled a logistic exchange function with a payback percentage of 60 percent, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36619 through 36621).

For the FY 2027 program year, we will reduce each SNF's adjusted Federal per diem rate by 2 percent. We will then

redistribute 60 percent of that 2 percent withhold to SNFs based on their measure performance. Additionally, in the FY 2023 SNF PPS final rule (87 FR 47585 through 47587), we finalized a case minimum requirement for the SNFRM, Total Nurse Staffing, SNF HAI, and DTC PAC SNF measures, and in the FY 2024 SNF PPS final rule (88 FR 53301 through 53302) we finalized a case minimum requirement for the Nursing Staff Turnover, Falls with Major Injury (Long-Stay), Long Stay Hospitalization, and DC Function measures, as required by section 1888(h)(1)(C)(i) of the Act. Furthermore, in the FY 2024 SNF PPS final rule (88 FR 53302 through 53303), we finalized the measure minimum requirement for the FY 2027 SNF VBP program year, as required by section 1888(h)(1)(C)(ii) of the Act. As a result of these provisions, SNFs must meet the case minimum for at least four of the eight measures during the applicable performance period to receive a SNF performance score and value-based incentive payment for FY 2027; SNFs that do not meet the measure minimum requirement finalized for the FY 2027 program year will be excluded from the Program and will receive their adjusted Federal per diem rate for that fiscal year. This policy will maintain the overall payback percentage at 60 percent for the FY 2027 program year. Based on the 60 percent payback percentage, we estimated that we will redistribute approximately $311.98 million (of the estimated $519.97 million in withheld funds) in value-based incentive payments to SNFs in FY 2027, which means that the SNF VBP Program is estimated to result in approximately $207.99 million in savings to the Medicare Program in FY 2027.

Our detailed analysis of the impacts of the FY 2027 SNF VBP Program is shown in Tables 25, 26, and 27.

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TABLE 25: Estimated SNF VBP Program Impacts for FY 2027

Characteristic	Number of facilities	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean Total Nursing Hours per Resident Day (Total Nurse Staffing)	Mean Risk-Standardized Rate of Healthcare-Associated Infections (SNF HAI) (%)	Mean Total Nursing Staff Turnover Rate (Nursing Staff Turnover) (%)
Group					
Total*	13,489	20.29	3.80	7.16	49.67
Urban	9,918	20.37	3.80	7.18	49.92
Rural	3,571	20.07	3.81	7.11	48.97
Hospital-based urban**	203	20.08	4.96	6.35	41.22
Freestanding urban**	9,711	20.38	3.78	7.19	50.08
Hospital-based rural**	132	19.61	4.93	6.53	42.12
Freestanding rural**	3,400	20.08	3.77	7.14	49.21
Urban by region					
New England	663	20.54	3.92	6.86	44.76
Middle Atlantic	1,375	20.17	3.68	7.15	44.78
South Atlantic	1,808	20.47	3.84	7.32	49.91
East North Central	1,820	20.59	3.43	7.06	52.36
East South Central	508	20.54	3.93	7.26	52.14
West North Central	786	20.12	4.15	6.81	55.39
West South Central	1,176	20.81	3.62	7.38	55.88
Mountain	479	19.76	3.87	6.75	53.46
Pacific	1,300	19.97	4.23	7.50	43.98
Outlying	3	20.81	3.42	7.18	38.55
Rural by region					
New England	98	19.66	4.12	6.69	51.92
Middle Atlantic	189	19.68	3.55	6.91	47.39
South Atlantic	430	20.30	3.70	7.33	49.78
East North Central	774	20.11	3.46	7.00	47.27
East South Central	446	20.18	3.94	7.32	45.91
West North Central	794	19.86	4.08	6.96	49.83
West South Central	579	20.52	3.79	7.42	49.76
Mountain	180	19.59	3.96	6.70	55.72
Pacific	81	18.78	4.31	6.64	48.81
Outlying	N/A	N/A	N/A	N/A	N/A
Ownership					
Government	769	20.04	4.15	6.98	45.64
Profit	9,943	20.41	3.62	7.32	51.01
Non-Profit	2,777	19.95	4.38	6.63	45.81

* The total group category excludes 1,398 SNFs that failed to meet the finalized measure minimum requirement.

** The group category that includes hospital-based/freestanding by urban/rural excludes 43 swing bed SNFs that satisfied the finalized measure minimum requirement.

N/A = Not available because no facilities in this group received a measure result.

TABLE 26: Estimated SNF VBP Program Impacts for FY 2027

Characteristic	Number of facilities	Mean risk-standardized discharge to community rate (DTC PAC SNF) (%)	Mean number of risk-adjusted hospitalizations per 1,000 long-stay resident days (Long stay Hospitalization)	Mean percentage of stays meeting or exceeding expected discharge function score (DC Function) (%)	Mean percentage of stays with a fall with major injury (Falls with Major Injury (Long-Stay)) (%)
Group					
Total*	13,489	49.81	1.89	51.01	3.32
Urban	9,918	50.56	1.92	50.78	3.04
Rural	3,571	47.69	1.80	51.65	4.10
Hospital-based urban**	203	58.88	1.46	48.31	2.38
Freestanding urban**	9,711	50.38	1.92	50.83	3.05
Hospital-based rural**	132	51.89	1.47	50.09	3.88
Freestanding rural**	3,400	47.31	1.81	51.79	4.10
Urban by region					
New England	663	54.24	1.86	53.81	3.56
Middle Atlantic	1,375	48.64	1.81	52.38	2.97
South Atlantic	1,808	50.26	1.91	50.97	3.03
East North Central	1,820	50.69	1.86	46.88	3.27
East South Central	508	50.34	1.98	50.16	3.38
West North Central	786	50.00	1.93	53.06	3.75
West South Central	1,176	48.24	2.23	52.06	3.30
Mountain	479	55.49	1.44	54.06	2.62
Pacific	1,300	51.69	1.99	49.21	1.86
Outlying	3	57.86	N/A	60.32	0.00
Rural by region					
New England	98	50.86	1.59	54.17	4.90
Middle Atlantic	189	45.06	1.46	49.85	3.51
South Atlantic	430	47.11	1.83	48.55	3.68
East North Central	774	50.23	1.68	47.39	4.02
East South Central	446	48.23	2.04	49.77	3.73
West North Central	794	45.56	1.72	54.19	4.49
West South Central	579	46.12	2.26	55.36	4.34
Mountain	180	49.79	1.28	58.84	4.36
Pacific	81	53.66	1.18	53.99	3.15
Outlying	N/A	N/A	N/A	N/A	N/A
Ownership					
Government	769	49.12	1.80	51.41	3.87
Profit	9,943	49.02	1.95	50.36	3.12
Non-Profit	2,777	52.82	1.67	53.25	3.87

* The total group category excludes 1,398 SNFs that failed to meet the finalized measure minimum requirement.

** The group category that includes hospital-based/freestanding by urban/rural excludes 43 swing bed SNFs that satisfied the finalized measure minimum requirement.

TABLE 27: Estimated SNF VBP Program Impacts for FY 2027

Characteristic	Number of facilities	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Group				
Total*	13,489	34.5322	0.99124	100.00
Urban	9,918	34.7951	0.99142	85.99
Rural	3,571	33.8019	0.99074	14.01
Hospital-based urban**	203	50.0527	1.00382	1.43
Freestanding urban**	9,711	34.4668	0.99115	84.54
Hospital-based rural**	132	47.9691	1.00124	0.30
Freestanding rural**	3,400	32.9851	0.99012	13.63
Urban by region				
New England	663	37.4371	0.99279	5.37
Middle Atlantic	1,375	35.9036	0.99192	19.10
South Atlantic	1,808	34.1613	0.99076	16.47
East North Central	1,820	31.5789	0.98930	10.97
East South Central	508	33.0967	0.99021	2.90
West North Central	786	35.2464	0.99214	3.68
West South Central	1,176	28.6368	0.98735	6.80
Mountain	479	41.0085	0.99608	3.66
Pacific	1,300	41.3129	0.99607	17.04
Outlying	3	42.9683	0.99607	0.00
Rural by region				
New England	98	39.4134	0.99466	0.53
Middle Atlantic	189	34.4778	0.99090	0.94
South Atlantic	430	31.3068	0.98879	1.99
East North Central	774	32.9949	0.99022	3.16
East South Central	446	33.7625	0.99079	1.86
West North Central	794	35.0889	0.99171	1.94
West South Central	579	30.1175	0.98800	2.26
Mountain	180	39.5987	0.99499	0.63
Pacific	81	47.4467	1.00149	0.70
Outlying	N/A	N/A	N/A	N/A
Ownership				
Government	769	38.3377	0.99425	3.20
Profit	9,943	32.2322	0.98948	80.89
Non-Profit	2,777	41.7133	0.99673	15.91

* The total group category excludes 1,398 SNFs that failed to meet the finalized measure minimum requirement. The total group category includes 61 SNFs that did not have historical payment data used for this analysis.

** The group category that includes hospital-based/freestanding by urban/rural excludes 43 swing bed SNFs that satisfied the measure minimum requirement.

N/A = Not available because no facilities in this group met the finalized measure minimum requirement.

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8. Alternatives Considered

As described in this section, we estimate that the aggregate impact of the provisions in this final rule will result in an increase of approximately $1.16 billion (3.2 percent) in Part A payments to SNFs in FY 2026. This reflects a $1.16 billion (3.2 percent) increase from the update to the payment rates.

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

requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY; accordingly, we are not pursuing alternatives for this process.

With regard to the updates for the SNF QRP, we are removing four standardized patient assessment data elements. We considered keeping these items but believe that removing them will help reduce burden for SNFs. With regard to the update to amend and codify our reconsideration policy and process, we considered the alternative of leaving the regulatory language unchanged. However, we believe it will be beneficial for SNFs to codify our specific bases for granting a reconsideration request and clarify the process for requesting an extension to the reconsideration request deadline.

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

9. Accounting Statement

Consistent with OMB Circular A–4 (available online at *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Tables 28, 29, and 30, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule for FY 2026. Tables 19 and 28 provide our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies outlined in this final rule, based on the data for 15,288 SNFs in our database.

TABLE 28: Accounting Statement: Classification of Estimated Expenditures, from the 2025 SNF PPS FY to the 2026 SNF PPS FY

Category	Transfers
Annualized Monetized Transfers	$1.16 billion
From Whom To Whom?	Federal Government to SNF Medicare Providers

TABLE 29: Accounting Statement: Classification of Estimated Expenditures for the Changes to the SNF QRP Program

Category	Transfers/Costs
Estimated Costs to all SNFs for Changes to the SNF QRP Program	-$2.2 million
Estimated Costs to those SNFs requesting an extension to file a request for reconsideration	+ $2,391.90

TABLE 30: Accounting Statement: Classification of Estimated Expenditures for the FY 2026 SNF VBP Program

Category	Transfers
Annualized Monetized Transfers	$312.53 million *
From Whom To Whom?	Federal Government to SNF Medicare Providers

*This estimate does not include the 2 percent reduction to SNFs' Medicare payments (estimated to be $520.89 million) required by statute.

TABLE 31: Accounting Statement: Classification of Estimated Expenditures for the FY 2027 SNF VBP Program

Category	Transfers
Annualized Monetized Transfers	$311.98 million *
From Whom To Whom?	Federal Government to SNF Medicare Providers

*This estimate does not include the 2 percent reduction to SNFs' Medicare payments (estimated to be $519.97 million) required by statute.

10. Conclusion

This rule updates the SNF PPS rates contained in the FY 2025 SNF PPS final rule (89 FR 64048). As outlined in the final rule, we estimate that the overall payments for SNFs under the SNF PPS in FY 2026 are projected to increase by approximately $1.16 billion, or 3.2 percent, compared with those in FY 2025. We estimate that in FY 2026, SNFs in urban and rural areas will experience, on average, a 3.1 percent increase and 3.7 percent increase, respectively, in estimated payments compared with FY 2025. Providers in the rural Mountain region will experience the largest estimated increase in payments of approximately 6.5 percent. Providers in the urban Pacific region will experience the smallest estimated increase in payments of 2.0 percent.

B. Regulatory Flexibility Act Analysis

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

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2025 (89 FR 64048). As outlined in the final rule, we estimate that the aggregate impact for FY 2026 will be an increase of $1.16 billion in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 19 that all providers will experience a net increase in payments, we note that some individual providers within the same region or group may experience different impacts on payments than others due to the distributional impact of the FY 2026 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. In their March 2025 Report to Congress (available at *https://www.medpac.gov/wp-content/uploads/2025/03/Mar25*), MedPAC states that Fee-for-Service Medicare accounted for approximately 8 percent of total patient days in freestanding facilities and 14 percent of facility revenue in 2022. As indicated in Table 19, the effect on facilities is projected to be an aggregate positive impact of 3.2 percent for FY 2026. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent of the total revenue. Since Medicare accounts for only 14 percent of SNF total revenue, the resulting impact of the final rule is 0.45 percent (14 percent of 3.2 percent). As the overall impact on small entities do not meet the 3 to 5 percent threshold discussed previously, the Secretary has determined that this final rule will not have a significant impact on a substantial number of small entities for FY 2026.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. This final rule will affect small rural hospitals that: (1) furnish SNF services under a swing-bed agreement or (2) have a hospital-based SNF. We anticipate that the impact on small rural hospitals will be similar to the impact on SNF providers overall. Moreover, as noted in previous SNF PPS final rules (most recently, the one for FY 2025 (89 FR 64048)), the category of small rural hospitals is included within the analysis of the impact of the final rule on small entities in general. As indicated in Table 19, the effect on facilities for FY 2026 is projected to be an aggregate positive impact of 3.2 percent for Medicare payments only. As the overall impact on the industry as a whole does not meet the 3 to 5 percent threshold discussed previously, the Secretary has determined that this final rule will not have a significant impact on a substantial number of small rural hospitals for FY 2026.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. This final rule will impose no mandates on State, local, or Tribal governments or on the private sector.

D. Federalism Analysis

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

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on this year's proposed rule will be the number of reviewers of this year's final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed this year's proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons, we believe that the number of commenters on this year's proposed rule is a fair estimate of the number of reviewers of this.

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

The mean wage rate for medical and health service managers (SOC 11–9111) in BLS Occupational Employment Wage

Statistics is $64.64, assuming benefits plus other overhead costs equal 100 percent of wage rate, we estimate that the cost of reviewing this rule is $129.28 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm.* Assuming an average reading speed, we estimate that it will take approximately 4 hours for the staff to review half of this final rule. For each SNF that reviews the rule, the estimated cost is $517.12 (4 hours × $129.28). Therefore, we estimate that the total cost of reviewing this regulation is $38,266.88 ($517.12 × 74 reviewers).

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

Executive Order 14192, entitled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' This rule is expected to be an E.O. 14192 deregulatory action. We estimated that this rule will generate $1.97 million in annualized cost savings at a 7 percent discount rate, discounted relative to year 2024, over a perpetual time horizon.

In accordance with the provisions of Executive Order 12866, this final rule has been reviewed by the Office of Management and Budget.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 28, 2025.

List of Subjects in 42 CFR Part 413

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

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

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

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

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

■ 2. Section 413.338 is amended by—

■ a. In paragraph (a), removing the terms ''Health equity adjustment (HEA) bonus points'', ''Measure performance scaler'', ''Top tier performing SNF'', ''Underserved multiplier'', and ''Underserved population'';
■ b. Revising paragraph (c)(2)(i);
■ c. Removing paragraph (e)(3)(iii);
■ d. Revising paragraphs (f)(2) and (3);
■ e. Adding paragraph (f)(6);
■ f. Removing paragraph (k); and
■ g. Redesignating paragraphs (l) through (n) as paragraphs (k) through (m) respectively.

The revisions and addition read as follows:

§ 413.338 Skilled nursing facility value-based purchasing program.

* * * * *

(c) * * *

(2) * * *

(i) *Total amount available for a fiscal year.* The total amount available for value-based incentive payments for a fiscal year is at least 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS, and will be increased as appropriate for each fiscal year to account for the assignment of a performance score to low-volume SNFs under paragraph (d)(3) of this section. Beginning with the FY 2023 SNF VBP, the total amount available for value-based incentive payments for a fiscal year is 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS.

* * * * *

(f) * * *

(2) Beginning with the baseline period and performance period quality measure quarterly reports issued on or after October 1, 2021, which contain the baseline period and performance period measure rates, respectively, SNFs will have 30 days following the date CMS provides each of these reports to review and submit corrections to the measure rate calculations contained in that report. The underlying data used to calculate the measure rates are not subject to review and correction under this paragraph (f)(2). Any correction requests submitted under this paragraph (f)(2) must include all of the following and be submitted by email to the SNF VBP Program Help Desk:

(i) The SNF's CMS Certification Number (CCN);

(ii) The SNF's name;

(iii) The correction requested; and

(iv) The reason for requesting the correction, including any available evidence to support the request.

(3) Beginning not later than 60 days prior to each fiscal year, CMS will provide reports to SNFs on their performance under the SNF VBP Program for a fiscal year. SNFs will have the opportunity to review and submit corrections to their SNF performance scores and ranking contained in these reports for 30 days following the date that CMS provides the reports. Any correction requests submitted under this paragraph (f)(3) must include all of the following and be submitted by email to the SNF VBP Program Help Desk:

(i) The SNF's CMS Certification Number (CCN);

(ii) The SNF's name;

(iii) The correction requested; and

(iv) The reason for requesting the correction, including any available evidence to support the request.

* * * * *

(6) Beginning with quarterly confidential feedback reports issued on or after October 1, 2025, a SNF that is not satisfied with the decision by CMS on a review and correction request submitted under paragraph (f)(2) or (3) of this section may seek reconsideration of that decision by submitting a reconsideration request no later than 15 calendar days from the day after the date noted in the decision. SNFs must submit their reconsideration requests via email in the form and manner specified by CMS in the review and correction decision. The reconsideration request must contain all of the following:

(i) The SNF's CMS Certification Number (CCN);

(ii) The SNF's name;

(iii) The issue for which the SNF submitted a review and correction request, received a review and correction decision, and are requesting reconsideration; and

(iv) The reason why the SNF is requesting reconsideration, which can be supported by any applicable documentation or other evidence.

* * * * *

■ 3. Section 413.360 is amended by revising paragraph (d)(4) and adding paragraphs (d)(5) and (6) to read as follows:—

§ 413.360 Requirements under the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

* * * * *

(d) * * *

(4) CMS will notify the SNF, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: CMS designated data submission system, the United States Postal Service, or via email from the CMS Medicare Administrative Contractor (MAC). CMS

will grant a timely request for reconsideration, and reverse an initial finding of non-compliance, only if CMS determines that the SNF was in full compliance with the SNF QRP requirements for the applicable program year.

(5) A SNF may request, and CMS may grant, an extension to file a reconsideration request if, during the period to request a reconsideration as set forth in paragraph (d)(1) of this section, the SNF was affected by an extraordinary circumstance beyond the control of the SNF (for example, a natural or man-made disaster). A SNF must submit its request for an extension to file a reconsideration request no later than 30 calendar days from the date of the written notification of noncompliance. The SNF must submit its request for an extension to CMS via email to *SNFQRPReconsiderations@cms.hhs.gov,* and must contain all of the following information:

(i) SNF CCN.

(ii) SNF Business Name.

(iii) SNF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) A statement of the reason for the request for the extension.

(vi) Evidence of the impact of the extraordinary circumstances, including, for example, photographs, newspaper articles, and other media.

(6) CMS will notify the SNF, in writing, of its final decision regarding its request for an extension to file a reconsideration of noncompliance request via an email from CMS.

* * * * *

Robert F. Kennedy Jr.,

Secretary, Department of Health and Human Services.

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