DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1827–P]

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: Proposed rule.

SUMMARY: This proposed rule would change and update policies and payment rates used under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for FY 2026. This rulemaking also proposes to update the requirements for the SNF Quality Reporting Program and the SNF Value-Based Purchasing Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by June 30, 2025.

ADDRESSES: In commenting, please refer to file code CMS–1827–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1827–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1827–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Patricia Taft, (410) 786–4561, 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:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

Unleashing Prosperity Through Deregulation of the Medicare Program—Request for Information: On January 31, 2025, President Trump issued Executive Order (E.O.) 14192 ''Unleashing Prosperity Through Deregulation,'' which states the Administration policy to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. We would like public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other stakeholders participating in the Medicare program. CMS has made available a Request for Information (RFI) at: *https://www.cms.gov/medicare-regulatory-relief-rfi.* Please submit all comments in response to this request for information through the provided weblink.

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 proposed 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.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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I. Executive Summary

A. Purpose

This proposed rule would update the 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 responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication of certain specified information relating to the payment update (see section II.C. of this proposed rule) in the **Federal Register** before the August 1 that precedes the start of each FY. We are also proposing several technical revisions to the code mappings used to classify patients under the Patient Driven Payment Model (PDPM) to improve payment and coding accuracy. We are proposing updates to the requirements for the SNF QRP by removing four standardized patient assessment data elements under the SDOH category and proposing to amend our reconsideration policy and process. We are also including 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. This proposed rule also proposes updates to the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, including removing the Health Equity Adjustment, estimating performance standards, 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 CMS's decisions on review and correction requests, and technical updates to the SNF VBP Program's regulation text.

B. Summary of Major Provisions

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

For the SNF VBP Program, we are providing estimated performance standards for the FY 2028 and FY 2029 program years to comply with the program's statutory notice deadline. Second, we are proposing to apply the previously finalized scoring methodology codified at § 413.338(e)(1) and § 413.338(e)(3) of our regulations to the Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (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 proposing 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 proposing to remove the Health Equity Adjustment to simplify the methodology and provide clearer incentives for SNFs as they seek to improve their quality of care for all residents.

Finally, we are proposing two updates for the SNF QRP. Beginning with residents admitted on October 1, 2025, for the FY 2027 SNF QRP, we are proposing to remove four standardized patient assessment data elements under the social determinants of health (SDOH) category. We are also proposing to amend and codify our reconsideration request policy and process. We are also including 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.

C. Summary of Cost and Benefits

TABLE 1—ESTIMATED COST AND BENEFITS

Proposals	Estimated total transfers/costs
FY 2026 SNF PPS payment rate update	The overall economic impact of this proposed rule is an estimated increase of $997 million in aggregate payments to SNFs during FY 2026.
FY 2027 SNF QRP changes due to the proposed Removal of Four Standardized Patient Assessment Data Elements.	The overall economic impact of this proposal to SNFs is an estimated decrease of $2,228,563.12 annually to SNFs beginning with the FY 2027 SNF QRP.
FY 2027 SNF QRP changes due to the proposed 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 proposal 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 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 Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered 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. 11393, enacted April 1, 2014) added 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) of the Act, authorizing the Secretary to apply up to nine additional 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 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 later in this preamble, this proposed rule will set out the required annual updates to the per diem payment rates for SNFs for FY 2026.

III. Proposed 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 Part B add-on, which is an estimate of the amounts that, prior to the SNF PPS, would be payable under Part B for covered SNF services furnished to individuals during the course of a covered 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 proposed rule.

As outlined in this proposed rule, we propose 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 propose that if more recent data subsequently become 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.

2. Market Basket Update 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 proposed 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. This process yields a percentage increase in the 2022-based SNF market basket of 3.0 percent.

As further explained in section III.B.3. of this proposed rule, as applicable, we adjust 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 0.8 percentage point, as described in section III.B.4. of this proposed 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 fiscal year will receive a 2.0 percentage point reduction to their market basket update for the fiscal year 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 fiscal year and may result in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. 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 fiscal year involved, and that the reduction cannot be taken into account in computing the payment amount for a subsequent fiscal year.

3. Forecast Error Adjustment

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

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 3.0 percent is adjusted upward to account for the forecast error adjustment of 0.6 percentage point, resulting in a proposed FY 2026 SNF market basket percentage increase of 3.6 percent, which is then reduced by the proposed productivity adjustment of 0.8 percentage point, discussed in section III.B.4. of this proposed rule. This results in a proposed SNF market basket update for FY 2026 of 2.8 percent.

Table 2 shows the forecasted and actual market basket percentage increases for FY 2024.

TABLE 2—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 fourth quarter 2024 IHS Global Inc. forecast (2018-based SNF market basket), with historical data through third quarter 2024.

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 for the 10-year period ending with the applicable FY, year, cost-reporting period, or other annual period).

The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measure of productivity for the U.S. 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.''

Per 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) 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 fiscal year. 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 this FY 2026 SNF PPS proposed rule, 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 projected to be 0.8 percentage point.

Consistent with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2), and as outlined previously in section III.B.1. of this proposed rule, the market basket percentage increase for FY 2026 for the SNF PPS is based on IHS Global Inc.'s fourth quarter 2024 forecast of the SNF market basket percentage increase, which is estimated to be 3.0 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 proposed rule. Finally, as outlined earlier in this section, we are applying a proposed 0.8 percentage point productivity adjustment to the FY 2026 SNF market basket percentage increase. Therefore, the resulting proposed FY 2026 SNF market basket update is equal to 2.8 percent, which reflects a proposed market basket percentage increase of 3.0 percent, plus the proposed 0.6 percentage point forecast error adjustment, reduced by the proposed 0.8 percentage point productivity adjustment. Thus, we apply a net proposed SNF market basket update factor of 2.8 percent in our determination of the proposed FY 2026 SNF PPS unadjusted Federal per diem rates.

5. Unadjusted Federal Per Diem Rates for FY 2026

As discussed 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 discussed 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 propose to use the SNF market basket update, adjusted as outlined previously in sections III.B.1. through III.B.4. of this proposed 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 proposed 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 3 and 4 reflect the proposed unadjusted Federal rates for FY 2026, prior to adjustment for case-mix.

TABLE 3—PROPOSED FY 2026 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$75.42	$70.20	$28.16	$131.47	$99.19	$117.73

TABLE 4—PROPOSED FY 2026 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$85.98	$78.96	$35.48	$125.61	94.76	$119.91

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 MDS to assign case-mix classifiers to each patient that are then used to calculate a per diem payment under the SNF PPS, consistent with the provisions of section 1888(e)(4)(G)(i) of the Act. As outlined in section IV.A. of the proposed 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 we have stated in prior rules, for an MDS to be considered valid for use in determining payment, the MDS assessment should 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 proposed 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 5 and 6 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 5 and 6 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 A5 and A6 reflect the PDPM's structure. Accordingly, Column 1 of Tables A5 and A6 represents the character in the HIPPS code associated with a given PDPM component. Columns 2 and 3 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant PT group. Columns 4 and 5 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant OT group. Columns 6 and 7 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant SLP group. Column 8 provides the nursing case-mix group (CMG) that is connected with a given PDPM HIPPS character. For example, if the patient qualified for the nursing group CBC1, then the third character in the patient's HIPPS code would be a ''P.'' Columns 9 and 10 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant nursing group. Finally, columns 11 and 12 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant NTA group.

Tables 5 and 6 do not reflect adjustments which may be made to the SNF PPS rates as a result of the SNF VBP Program, outlined in section VII. of this proposed rule, or other adjustments, such as the variable per diem adjustment.

TABLE 5—PDPM CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN

PDPM group	PT CMI	PT rate	OT CMI	OT rate	SLP CMI	SLP rate	Nursing CMG	Nursing CMI	Nursing rate	NTA CMI	NTA rate
A	1.45	$109.36	1.41	$98.98	0.64	$18.02	ES3	3.84	$504.84	3.06	$303.52
B	1.61	121.43	1.54	108.11	1.72	48.44	ES2	2.90	381.26	2.39	237.06
C	1.78	134.25	1.60	112.32	2.52	70.96	ES1	2.77	364.17	1.74	172.59
D	1.81	136.51	1.45	101.79	1.38	38.86	HDE2	2.27	298.44	1.26	124.98
E	1.34	101.06	1.33	93.37	2.21	62.23	HDE1	1.88	247.16	0.91	90.26
F	1.52	114.64	1.51	106.00	2.82	79.41	HBC2	2.12	278.72	0.68	67.45
G	1.58	119.16	1.55	108.81	1.93	54.35	HBC1	1.76	231.39	.....	.....
H	1.10	82.96	1.09	76.52	2.7	76.03	LDE2	1.97	259.00	.....	.....
I	1.07	80.70	1.12	78.62	3.34	94.05	LDE1	1.64	215.61	.....	.....
J	1.34	101.06	1.37	96.17	2.83	79.69	LBC2	1.63	214.30	.....	.....
K	1.44	108.60	1.46	102.49	3.50	98.56	LBC1	1.35	177.48	.....	.....
L	1.03	77.68	1.05	73.71	3.98	112.08	CDE2	1.77	232.70	.....	.....
M	1.20	90.50	1.23	86.35	.....	.....	CDE1	1.53	201.15	.....	.....
N	1.40	105.59	1.42	99.68	.....	.....	CBC2	1.47	193.26	.....	.....
O	1.47	110.87	1.47	103.19	.....	.....	CA2	1.03	135.41	.....	.....
P	1.02	76.93	1.03	72.31	.....	.....	CBC1	1.27	166.97	.....	.....
Q	.....	.....	.....	.....	.....	.....	CA1	0.89	117.01	.....	.....
R	.....	.....	.....	.....	.....	.....	BAB2	0.98	128.84	.....	.....
S	.....	.....	.....	.....	.....	.....	BAB1	0.94	123.58	.....	.....
T	.....	.....	.....	.....	.....	.....	PDE2	1.48	194.58	.....	.....
U	.....	.....	.....	.....	.....	.....	PDE1	1.39	182.74	.....	.....
V	.....	.....	.....	.....	.....	.....	PBC2	1.15	151.19	.....	.....
W	.....	.....	.....	.....	.....	.....	PA2	0.67	88.08	.....	.....
X	.....	.....	.....	.....	.....	.....	PBC1	1.07	140.67	.....	.....
Y	.....	.....	.....	.....	.....	.....	PA1	0.62	81.51	.....	.....

TABLE 6—PDPM CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL

PDPM group	PT CMI	PT rate	OT CMI	OT rate	SLP CMI	SLP rate	Nursing CMG	Nursing CMI	Nursing rate	NTA CMI	NTA rate
A	1.45	$124.67	1.41	$111.33	0.64	$22.71	ES3	3.84	$482.34	3.06	$289.97
B	1.61	138.43	1.54	121.60	1.72	61.03	ES2	2.90	364.27	2.39	226.48
C	1.78	153.04	1.60	126.34	2.52	89.41	ES1	2.77	347.94	1.74	164.88
D	1.81	155.62	1.45	114.49	1.38	48.96	HDE2	2.27	285.13	1.26	119.40
E	1.34	115.21	1.33	105.02	2.21	78.41	HDE1	1.88	236.15	0.91	86.23
F	1.52	130.69	1.51	119.23	2.82	100.05	HBC2	2.12	266.29	0.68	64.44
G	1.58	135.85	1.55	122.39	1.93	68.48	HBC1	1.76	221.07	.....	.....
H	1.10	94.58	1.09	86.07	2.7	95.80	LDE2	1.97	247.45	.....	.....
I	1.07	92.00	1.12	88.44	3.34	118.50	LDE1	1.64	206.00	.....	.....
J	1.34	115.21	1.37	108.18	2.83	100.41	LBC2	1.63	204.74	.....	.....
K	1.44	123.81	1.46	115.28	3.50	124.18	LBC1	1.35	169.57	.....	.....
L	1.03	88.56	1.05	82.91	3.98	141.21	CDE2	1.77	222.33	.....	.....
M	1.20	103.18	1.23	97.12	.....	.....	CDE1	1.53	192.18	.....	.....
N	1.40	120.37	1.42	112.12	.....	.....	CBC2	1.47	184.65	.....	.....
O	1.47	126.39	1.47	116.07	.....	.....	CA2	1.03	129.38	.....	.....
P	1.02	87.70	1.03	81.33	.....	.....	CBC1	1.27	159.52	.....	.....
Q	.....	.....	.....	.....	.....	.....	CA1	0.89	111.79	.....	.....
R	.....	.....	.....	.....	.....	.....	BAB2	0.98	123.10	.....	.....
S	.....	.....	.....	.....	.....	.....	BAB1	0.94	118.07	.....	.....
T	.....	.....	.....	.....	.....	.....	PDE2	1.48	185.90	.....	.....
U	.....	.....	.....	.....	.....	.....	PDE1	1.39	174.60	.....	.....
V	.....	.....	.....	.....	.....	.....	PBC2	1.15	144.45	.....	.....
W	.....	.....	.....	.....	.....	.....	PA2	0.67	84.16	.....	.....
X	.....	.....	.....	.....	.....	.....	PBC1	1.07	134.40	.....	.....
Y	.....	.....	.....	.....	.....	.....	PA1	0.62	77.88	.....	.....

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 propose to 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 propose 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).

We note that 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.

In addition, we propose to 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 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 discussed 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 fiscal year (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 we previously 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 discussed 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 propose 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 SNF PPS final rule for FY 2025 (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.

TABLE 7—LABOR-RELATED SHARE, FY 2025 AND FY 2026

	Relative importance, labor-related share, FY 2025 24:2 forecast [1]	Proposed relative importance, labor-related share, FY 2026 24:4 forecast [2]
Wages and Salaries	53.2	53.3
Employee Benefits	9.2	9.0
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 fourth quarter 2024 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 7. 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 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 9.

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 proposed budget neutrality factor for FY 2026 is 1.0016.

We are also proposing 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.

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 fiscal year 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 fiscal year 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).

Please see section VII. of this proposed rule for further discussion of the updates we are proposing for the SNF VBP Program.

F. Adjusted Rate Computation Example

Tables 8 through 10 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 8 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 9 shows the adjustments made to the case-mix adjusted per diem rate from Table 8 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 A available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Finally, Table 10 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 10 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 10, SNF XYZ's total PPS payment for this particular patient's stay would equal $23,529.37.

TABLE 8—PDPM CASE-MIX ADJUSTED RATE COMPUTATION EXAMPLE

Per diem rate calculation				
Component	Component group	Component rate	VPD adjustment factor	VPD adj. rate
PT	N	$105.59	1.00	$105.59
OT	N	99.68	1.00	99.68
SLP	H	76.03	1.00	76.03
Nursing	N	193.26	1.00	193.26
NTA	C	172.59	3.00	517.77
Non-Case-Mix	.....	117.73	.....	117.73
Total PDPM Case-Mix Adj. Per Diem	.....	.....	.....	1,110.06

TABLE 9—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	$1,110.06	$798.13	0.9768	$779.61	$311.93	$1,091.54

TABLE 10—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	$1,091.54
2	3.0	1.0	1,091.54
3	3.0	1.0	1,091.54
4	1.0	1.0	752.12
5	1.0	1.0	752.12
6	1.0	1.0	752.12
7	1.0	1.0	752.12
8	1.0	1.0	752.12
9	1.0	1.0	752.12
10	1.0	1.0	752.12
11	1.0	1.0	752.12
12	1.0	1.0	752.12
13	1.0	1.0	752.12

TABLE 10—ADJUSTED RATE COMPUTATION EXAMPLE—Continued

Day of stay	NTA VPD adjustment factor	PT/OT VPD adjustment factor	Case mix and wage index adjusted per diem rate
14	1.0	1.0	752.12
15	1.0	1.0	752.12
16	1.0	1.0	752.12
17	1.0	1.0	752.12
18	1.0	1.0	752.12
19	1.0	1.0	752.12
20	1.0	1.0	752.12
21	1.0	0.98	748.08
22	1.0	0.98	748.08
23	1.0	0.98	748.08
24	1.0	0.98	748.08
25	1.0	0.98	748.08
26	1.0	0.98	748.08
27	1.0	0.98	748.08
28	1.0	0.96	744.05
29	1.0	0.96	744.05
30	1.0	0.96	744.05
Total Payment	.....	.....	23,529.37

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 III.C. of the proposed 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 we explained 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 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 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 SNF PPS proposed and final rules for FY 2001 (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 additional, individual services for exclusion within each of these four specified service categories. In the proposed rule for FY 2001, we also noted 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 we further explained in the final rule for FY 2001 (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 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 this proposed rule, we specifically solicit 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 may consider excluding a particular service if it meets our criteria for exclusion as specified previously in this section of the preamble. We request 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 note 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 noted in this section of the preamble, 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.*

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), 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 explained in the FY 2002 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 proposed 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 discussed 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 Patient Driven Payment Model (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 noted 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 are finalizing 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 Part-A covered SNF stay.

2. Proposed 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. This year, we are proposing to change the clinical category assignment for the following thirty-four new ICD–10 codes that were effective October 1, 2024.

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 would serve appropriately as the primary diagnoses for a Part A-covered SNF stay. As a result, we propose to change 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. However, these diagnoses are typically treated using interventions

such as, but not limited to, blood sugar monitoring education, dietary counseling, physical exercise education and training, pharmacological interventions, etc. 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 would serve appropriately as the primary diagnoses for a Part A-covered SNF stay. As a result, we propose to change 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, pharmacological interventions, etc. 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 would serve appropriately as the primary diagnoses for a Part A-covered SNF stay. As a result, we propose to change 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, pharmacological interventions, etc. 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 would serve appropriately as the primary diagnosis for a Part A-covered SNF stay. As a result, we propose to change 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, pharmacological interventions, etc. 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 would serve appropriately as the primary diagnoses for a Part A-covered SNF stay. As a result, we propose to change 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, pharmacological interventions, etc. 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 would serve appropriately as the primary diagnoses for a Part A-covered SNF stay. As a result, we propose to change 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, excessive exercise, etc. 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, pharmacological interventions, etc. 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 would serve appropriately as the primary diagnoses for a Part A-covered SNF stay. As a result, we propose to change 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, pharmacological interventions, etc. 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 would serve appropriately as the primary diagnoses for a Part A-covered SNF stay. As a result, we propose to change 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 due to drug interactions or the overdose of serotonergic medications. Code G90.81 (*Serotonin syndrome*) was initially assigned to the ''Acute Neurologic'' clinical category. However, this diagnosis may require testing and interventions, such as, but not limited to, identifying and discontinuing causative agents, symptom management and support, pharmacological management, education, and up to and including emergency care and/or ICU-admission depending on the severity. Given these interventions, treatment for this diagnosis, depending on severity, would typically occur on an outpatient basis or in an acute care hospital and not require an inpatient SNF stay in and of itself. Therefore, we do not believe this code would serve appropriately as the primary diagnosis for a Part A-covered SNF stay. As a result, we propose to change the mapping of this code from ''Acute Neurologic'' to the clinical category of ''Medical Management'.

We invite comments on the proposed changes to the PDPM ICD–10 mappings discussed earlier in this section.

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

A. Background and Statutory Authority

The Skilled Nursing Facility Quality Reporting Program (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 fiscal year (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 in our regulations at § 413.360.

In this proposed rule, we are proposing 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. We are also proposing to amend our reconsideration policy and process. We are also seeking public comment 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 we historically used for the selection of SNF QRP quality, resource use, or other measures, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46429 through 46431).

1. Quality Measures Currently Adopted for the SNF QRP

The SNF QRP currently has 15 adopted measures, which are set forth in Table 11. We are not proposing to adopt any new measures for the SNF QRP.

For a discussion of the factors we use to evaluate whether a measure should 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).

TABLE 11—QUALITY MEASURES CURRENTLY ADOPTED FOR THE 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 COVID19 Vaccine	COVID19 Vaccination Coverage among Healthcare Personnel (HCP).

TABLE 11—QUALITY MEASURES CURRENTLY ADOPTED FOR THE SNF QRP—Continued

Short name	Measure name & data source
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP).

C. Proposal To Remove 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 social determinants of health (SDOH) category: 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 this proposed rule, we are proposing to remove these four standardized patient assessment data elements under the SDOH category 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 burden of these data collections on health care providers. CMS has a goal 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 data elements being part of a low burden interoperable electronic system. The focus will turn towards how the data and associated recommendations exchanged can improve care coordination, efficiency, reduction in errors, and resident experience. As health information technology (HIT) 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. Under our proposal, SNFs would not be required to collect and submit Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330) beginning with residents admitted on or after October 1, 2025 as previously finalized. Under our proposal, these items would not be required to meet the SNF QRP requirements beginning with the FY 2027 SNF QRP.

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. We refer readers to section VIII.B.1. of this proposed rule for details on this estimated burden reduction.

We invite public comment on our proposal to remove four standardized patient assessment data elements collected under the SDOH category from the SNF QRP beginning with the FY 2027 SNF QRP.

D. Proposals To Amend the 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 CMS reducing the SNF's annual market basket percentage by 2 percent for the applicable fiscal year 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'' existed which 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).

As codified, our regulation at § 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.

We have become aware there are inconsistencies in our preamble and regulation text regarding SNF requests for reconsideration. On this basis, in this proposed rule, we seek to clarify these areas.

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

As noted previously, in the FY 2016 SNF PPS final rule, we stated that, in very 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, in our regulation text at § 413.360(d). In implementing this finalized policy, we have noted 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, as codified 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 are proposing to remove the term ''extenuating circumstances'' as used currently in our reconsideration policy and replace it with ''extraordinary circumstances.'' Specifically, we propose 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 propose 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 have noted some areas in our policy where SNFs may benefit from clearly demarcated deadlines. Although we believe a SNF would have an interest in asking 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 propose to amend our reconsideration policy as codified 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 propose 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 propose 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 propose to codify this process at § 413.360(d)(5).

We further propose that 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. We propose 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 propose to codify this process at § 413.360(d)(6).

We note that 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, CMS has received 202 reconsideration requests annually from SNFs. If all these SNFs submitted an extension to file a reconsideration request to CMS, we estimate 51 hours total of administrative burden at an increased cost of $2,391.90 for these SNFs. We refer readers to section X.A.6.b. of this proposed rule for details on this estimated increase in burden.

We invite comment on these proposals 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).

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

As discussed previously, in FY 2016 SNF PPS final rule (80 FR 46460), 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).

As previously discussed, 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). Our regulation at § 413.360(d)(2)(vi) requires that a SNF's request for reconsideration include the reason(s) for requesting reconsideration including all supporting documentation. As provided in § 413.360(d)(3), 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).

On these bases, we propose 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 would consider full compliance with the SNF QRP requirements to include CMS granting an exception or extension to SNF QRP reporting requirements under our ECE policy at § 413.360(c). However, to demonstrate full compliance with our ECE policy, the SNF would need to comply with our ECE policy's requirements, including the specific scope of the exception or extension as granted by CMS.

We propose to revise § 413.360(d)(4) to codify this modified policy in our regulation.

The remainder of the text at § 413.360(d)(4) would remain the same. We note that we are considering similar proposals across all post-acute care quality reporting programs to more closely align the reconsideration policies and processes.

We invite comment on these 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.

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

We are seeking input on the importance, relevance, appropriateness, and applicability of each of the quality measure concepts under consideration listed in Table 12 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 2024 SNF PPS proposed rule (88 FR 21353 through 21355), we included a request for information (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 2024 SNF PPS final rule (88 FR 53265 through 53267) for a summary of the public comments received in response to the RFI.

We are seeking input on four concepts for future measures for the SNF QRP.

TABLE 12—FUTURE MEASURE CONCEPTS UNDER CONSIDERATION FOR THE SNF QRP

Quality measure concepts
Interoperability.
Well-being.
Nutrition.
Delirium.

1. Interoperability

We are seeking input on the quality measure concept of interoperability, focusing on information technology systems' readiness and capabilities in the SNF setting. Title XXX of the Public Health Service Act defines ''interoperability'' in part, and with respect to health information technology (IT), as health IT that enables the secure exchange of electronic health information with, and use of electronic health information from, other health IT without requiring special efforts by the user.[1] The definition further states that interoperability of health IT allows for complete, including by providers and residents, access, exchange, and use of electronically accessible health information for authorized uses under applicable State or Federal Law.[2] We request input and comment on approaches to assessing interoperability in the SNF setting, for instance, measures that address or evaluate the level of readiness for interoperable data exchange, or measures that evaluate the ability of data systems to securely share information across the spectrum of care. Please provide input on the relevant aspects of interoperability for the SNF setting.

2. Well-Being

We are seeking input on a quality measure concept of well-being for future quality measures. We are seeking input on this concept for use in the SNF QRP with potential use in the SNF VBP. Well-being is a comprehensive approach to disease prevention and health promotion, as it integrates mental and physical health[3][4] while emphasizing preventative care to proactively address potential health issues. This comprehensive approach emphasizes person-centered care by promoting well-being of residents. We request input and comment on tools and measures that assess for overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, fulfillment, and self-care work. Please provide input on the relevant aspects of well-being for the SNF setting.

3. Nutrition

We are seeking input on a quality measure concept of nutrition for future quality measures. We are seeking input on this concept for use in the SNF QRP with potential use in the SNF VBP. Assessment of an individual's nutritional status may include various strategies, guidelines, and practices designed to promote healthy eating habits and ensure individuals receive the necessary nutrients for maintaining health, growth, and overall well-being. This also includes aspects of health that support or mediate nutritional status, such as physical activity and sleep. In this context, preventable care plays a vital role by proactively addressing factors that may lead to poor nutritional status or related health issues. These efforts not only support optimal nutrition but also work to prevent conditions that could otherwise hinder an individual's health and nutritional needs. We request input and comment on tools and frameworks that promote healthy eating habits, appropriate exercise, nutrition, or physical activity for optimal health, well-being, and best care for all. Please provide input on the relevant aspects of nutrition for the SNF setting.

4. Delirium

Finally, we are seeking input on a quality measure concept of delirium for future quality measures. Delirium, often under-detected, is a common complication of illness or injury that leads to negative health outcomes like frailty, cognitive impairment, and functional decline. Post-acute care residents experiencing delirium symptoms are more likely to undergo rehospitalization, experience poor functional recovery outcomes, and have a higher 6-month mortality rate compared to residents without delirium.[5] We request input and comment on the applicability of measures that evaluate for the sudden, serious change in a person's mental state or altered state of consciousness

[1] Public Health Service Act, 42 U.S.C. 3000(9) (2025).

[2] Public Health Service Act, 42 U.S.C. 3000(9) (2025).

[3] Overall well-being. See more information at *https://odphp.health.gov/healthypeople/objectives-and-data/overall-health-and-well-being-measures/overall-well-being-ohm-01.*

[4] Well-Being Measurement. See more information at *https://www.va.gov/WHOLEHEALTH/professional-resources/well-being.measurement.asp.*

[5] Marcantonio, E.R., Kiely, D.K., Simon, S.E., John Orav, E., Jones, R.N., Murphy, K.M., & Bergmann, M.A. (2005). Outcomes of older people admitted to postacute facilities with delirium. *Journal of the American Geriatrics Society, 53*(6), 963–969. *https://doi.org/10.1111/j.1532-5415.2005.53305.x.*

that may be associated with underlying symptoms or conditions. Please provide input on the relevant aspects of delirium for the SNF setting.

F. Potential Revision of the 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 nine 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.[6]

Currently, the largest contributing factor to the nine-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 three 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.[7] On these bases, we believe reducing the SNF QRP data submission deadline from 4.5 months to 45 days would 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 are requesting feedback on this potential future reduction of the SNF QRP data submission deadline from 4.5 months to 45 days that is under consideration. Specifically, we are requesting comment on:

- 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 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, we are issuing this request for information (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 information technology (IT) that enables information exchange using Fast Healthcare Interoperability Resources® (FHIR®) standards. Proposing 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

[6] 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.*

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

the FYs 2021, 2022, 2023 and 2024 SNF PPS proposed rules,[8] 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).
- To work with healthcare standards organizations to ensure their standards support our assessment tools.

We are considering 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 this RFI, we seek 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 are also seeking input on future measures under consideration including applicability of interoperability as a future measure concept in post-acute care settings, including the SNF QRP. Refer to section VI.E. of this proposed rule for more information.

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

2. Solicitation for Comment

We seek feedback 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 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? [9]
- Would your SNF and/or vendors be interested in participating in testing to

[8] ''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.*

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

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 invite any feedback, suggestions, best practices, or success stories related to the implementation of these technologies and will use this input to inform our future dQM transition efforts.

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

We are not currently proposing any new policies regarding the form, manner, and timing of data submitted *under the SNF QRP.* We refer readers to the current regulatory 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 are not currently proposing any new policies regarding the public display of measure data. 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, we refer readers to the FY 2017 SNF PPS final rule (81 FR 52045 through 52048).

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

A. Statutory Background

Through the Skilled Nursing Facility Value-Based Purchasing (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.

B. Proposed 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, rewards 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 we discussed 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 fiscal year, 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 fiscal year to account for the application of the HEA at § 413.338(c)(2)(i) of our regulations. 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. Proposal To Remove the Health Equity Adjustment Beginning With the FY 2027 Program Year

In this proposed rule, we are proposing to remove the HEA because we believe simplifying the SNF VBP Program's scoring methodology by removing the HEA will 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, the estimated 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 are proposing to remove the HEA at this time. We refer readers to the Supplementary Information at the start of this proposed rule for the Unleashing Prosperity Through Deregulation of the Medicare Program—Request for Information 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.

We also do not anticipate that any serious reliance interests would be impacted by this proposed rule.

We propose to codify this removal of the HEA by removing § 413.338 (k) and (e)(3)(iii) from our regulations, by removing terms related to the HEA in § 413.338 (a) of our regulations, and to revise § 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 welcome public comment on these proposals.

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 13 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 13—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.

D. SNF VBP Performance Standards

1. Background

Our current definitions for the performance standards are codified at § 413.338(a) of our regulations, and our current performance standards notification and updates policies are codified at § 413.338(n) of our regulations. 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. Estimated Performance Standards for the FY 2028 Program Year

To meet the requirements at section 1888(h)(3)(C) of the Act, we are providing estimated 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 previously finalized methodology for calculating performance standards (81 FR 51996 through 51998), the estimated numerical values for the FY 2028 program year performance standards are shown in Table 14. We will provide the final numerical performance standards for the remaining measures applicable for the FY 2028 program year in the FY 2026 SNF PPS final rule.

TABLE 14—ESTIMATED FY 2028 SNF VBP PROGRAM PERFORMANCE STANDARDS

Measure short name	Achievement threshold	Benchmark
SNF HAI Measure	0.92219	0.94693
Total Nurse Staffing Measure	3.21488	5.81159
Nursing Staff Turnover Measure	0.40230	0.75655
Falls with Major Injury (Long-Stay) Measure	0.95349	0.99950
Long Stay Hospitalization Measure	0.99758	0.99959
DC Function Measure	0.40000	0.78800

3. Estimated Performance Standards for the FY 2029 Program Year

To meet the requirements at section 1888(h)(3)(C) of the Act, we are providing estimated numerical performance standards for the FY 2029 program year for the DTC PAC SNF and SNF WS PPR measures. In accordance with our previously finalized methodology for calculating performance standards (81 FR 51996 through 51998), the estimated numerical values for the FY 2029 program year performance standards for the DTC PAC SNF and SNF WS PPR measures are shown in Table 15. We will provide the final numerical performance standards for the DTC PAC SNF and SNF WS PPR measures in the FY 2026 SNF PPS final rule.

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 15—ESTIMATED FY 2029 SNF VBP PROGRAM PERFORMANCE STANDARDS

Measure short name	Achievement threshold	Benchmark
DTC PAC SNF Measure	0.42612	0.67309
SNF WS PPR Measure	0.86372	0.92363

E. SNF VBP Performance Scoring Methodology

1. Proposed 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), 413.338(e)(3), and 413.338(k) of our regulations, and our current case minimum and measure minimum policies are codified at § 413.338(b) of our regulations. 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 and 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. Under this methodology, we will calculate the SNF performance score beginning with the FY 2027 program year as follows:

- We will 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;
- We will 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; and
- We will add to the SNF's normalized point total any applicable bonus points calculated such that the resulting point total is the overall SNF performance score for the fiscal year, except that no SNF performance score may exceed 100 points.

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 proposed to replace the SNFRM with the SNF WS PPR measure beginning with the FY 2028 program year.

b. Proposed 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. We are proposing to apply the previously finalized scoring methodology codified at § 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 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 invite public comment 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.

F. Proposal To Adopt a SNF VBP Program Reconsideration Process

1. Background

We refer readers to the FY 2025 SNF PPS final rule (89 FR 64133 through 64136) and to § 413.338(f) of our regulations 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) of our regulations, 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. And as codified at § 413.338(f)(1) of our regulations, 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) of our regulations, 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. Correction requests must contain all of the following:

- The SNF's CMS Certification Number (CCN).
- The SNF's name.
- The correction requested.
- 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 this proposed rule, we are proposing to adopt a reconsideration process that will 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 section 413.338(f)(2) or (f)(3). We are also proposing technical updates to our

regulation text to align the submission requirements for the proposed reconsideration process with the submission requirements under the review and correction process.

2. Proposed SNF VBP Program Reconsideration Process

Beginning with the FY 2027 SNF VBP program year, we are proposing to 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 proposed 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.

We are proposing that SNFs would be able to request this additional reconsideration only if they first submit a valid review and correction request described at §§ 413.338(f)(2) or (3) of our regulations and are dissatisfied with the decision.

Under this proposed reconsideration process, SNFs would have 15 calendar days 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 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:

- 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.
- 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 are also proposing to codify the proposed SNF VBP Program's reconsideration process at § 413.338(f)(6) of our regulations.

We welcome public comment on this proposal.

3. Proposed Regulation Text Technical Updates

We are proposing to codify 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 FY 2018 SNF PPS final rule (82 FR 36621 through 36623) but did not codify at that time. Specifically, we are proposing to update § 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 welcome public comment on these proposed technical updates to our regulation text.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 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 are soliciting public comment 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 Value-Based Purchasing Program

With regard to the SNF VBP Program, in section VII.F of this proposed rule, we are proposing to adopt a reconsideration process that will 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 section 413.338(f)(2) or (f)(3) of our regulations. We are also proposing to codify 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 FY 2018 SNF PPS final rule (82 FR 36621 through 36623) but did not codify at that time. The review and correction and reconsideration process would provide SNFs an opportunity to review information that is to be made public with respect to the facility prior to such information being made public, as required by section 1888(g)(6)(B) of the Act. This opportunity to review is exempt from the Paperwork Reduction Act, as specified by section 1888(g)(7) of the Act. This opportunity to review is also voluntary, and will not create any new, required reporting burdens for SNFs.

In addition, in section VII.B of this proposed rule, we are proposing to remove the Health Equity Adjustment previously adopted in the FY 2024 SNF PPS final rule (88 FR 53304 through 53318). The source of data we would have used to calculate this adjustment was the State Medicare Modernization Act (MMA) file of dual eligibility, therefore our calculation of this adjustment would not have created any additional reporting burden for SNFs, and thus removing the adjustment will also not create any new or revised reporting burdens for SNFs. Because this rule does not propose removing or adding any new or revised collection of information requirements or burden related to the SNF VBP Program, this section of the rule is not subject to OMB approval under the authority of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*). For the purpose of this section, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

If you comment on these information collections, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

B. 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 fiscal year if the SNF does not comply with the requirements of the SNF QRP for that fiscal year.

In section VI.C. of the proposed rule, we are proposing to remove four standardized patient assessment data elements under the SDOH category beginning with the FY 2027 SNF QRP.

In Section VI.D. of the proposed rule, we are also proposing 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 section X.A.6.b. of this proposed 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 are proposing to remove four standardized patient assessment data elements under the SDOH category previously adopted for collection and submission on admission 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 Paperwork Reduction Act of 1995 (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 proposed 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 would be 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.[10] To account for other indirect costs and fringe benefits, we doubled the median hourly wage. These amounts are detailed in Table 16. 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 Registered Nurse (RN) and Licensed Practical and Licensed Vocational Nurse (LPN/LVN) equally [($82.76/hr × 0.5) plus ($57.44/hr × 0.5) = $70.10].

TABLE 16—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

We estimate that the burden and cost for SNFs for complying with the requirements of the FY 2027 SNF QRP would decrease under this proposal. 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 × $70.10/hr) or $146.11 per SNF ($2,228,563.12/15,253 SNFs).

The total estimated burden associated with the proposed removal of four standardized patient assessment data elements at admission (as described in this section) is summarized in Table 17.

TABLE 17—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
Proposal to Remove of Four Standardized Patient Assessment Data Elements	−2.08	−$146.11	−31,791.20	$2,228,563.12

We invite 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

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

hours in burden per SNF at admission is an accurate estimate.

IX. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

X. Regulatory Impact Analysis

A. Statement of Need

1. Statutory Provisions

If finalized, this rule would update the FY 2026 SNF prospective payment rates as required under section 1888(e)(4)(E) of the Act. It also would respond 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, as described in section VI.C of this proposed rule, we are proposing to remove four standardized patient assessment data elements beginning with the FY 2027 SNF. As described in VI.D of this proposed rule, we are also proposing updates to our reconsideration policy and process under the statutory discretion afforded to the Secretary under section 1888(e)(6) of the Act.

With respect to the SNF VBP Program, this rule proposes updates to the SNF VBP Program requirements for FY 2026 and subsequent years. 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 proposed rule estimates 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 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 proposed 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 proposing several substantive changes to the PDPM ICD–10 code mapping.

3. Introduction

We have examined the impacts of this proposed 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).

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 would update the SNF PPS rates contained in the FY 2025 SNF PPS final rule (89 FR 64048). We estimate that the aggregate impact would be an increase of approximately $997 million (2.8 percent) in Part A payments to SNFs in FY 2026. We note in this proposed rule that these impact numbers do not incorporate the SNF VBP Program reductions that we estimate would 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 proposing to update 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 F18. 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 F18. 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 18 (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 F18 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 proposed 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 proposed 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 effect of all of the changes on the FY 2026 payments. The proposed update of 2.8 percent is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 2.8 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 18, 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 3.2 percent increase in FY 2026 total payments.

TABLE 18—IMPACT TO THE SNF PPS FOR FY 2026

Impact categories	Number of facilities	Update wage data (%)	Total change (%)
Group			
Total	15,253	0.0	2.8
Urban	11,054	−0.1	2.7
Rural	4,199	0.4	3.2
Hospital-based urban	329	−0.3	2.5
Freestanding urban	10,725	−0.1	2.7
Hospital-based rural	344	0.5	3.3
Freestanding rural	3,855	0.4	3.2
Urban by region			
New England	690	1.6	4.4
Middle Atlantic	1,432	−0.4	2.4
South Atlantic	1,889	0.2	3.0
East North Central	2,165	0.8	3.6
East South Central	559	0.5	3.3
West North Central	923	1.4	4.2
West South Central	1,451	−0.3	2.5
Mountain	529	0.2	3.0
Pacific	1,411	−1.1	1.7
Outlying	5	0.4	3.2
Rural by region			
New England	119	−0.4	2.4
Middle Atlantic	222	0.4	3.2
South Atlantic	520	0.1	2.9
East North Central	890	1.2	4.0
East South Central	470	−0.8	1.9
West North Central	972	0.4	3.2
West South Central	722	0.3	3.2
Mountain	195	2.2	5.0
Pacific	88	1.4	4.2
Outlying	1	0.2	3.0
Ownership			
For profit	10,920	−0.1	2.7
Non-profit	3,304	0.3	3.1

TABLE 18—IMPACT TO THE SNF PPS FOR FY 2026—Continued

Impact categories	Number of facilities	Update wage data (%)	Total change (%)
Government	1,029	0.3	3.1

Note: The Total column includes the FY 2026 proposed SNF market basket update of 2.8 percent. The values presented in Table 18 may not sum due to rounding.

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

Estimated impacts for the SNF QRP are based on analysis discussed in section VI. of the proposed 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 fiscal year if the SNF does not comply with the requirements of the SNF QRP for that fiscal year.

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 the proposed rule, we are proposing 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 21.

As discussed in section VIII.B.1. of this proposed rule, we estimate the net result of this proposal will decrease burden. If the proposal is finalized, SNFs would 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 × $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 decreased 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 the proposed rule, we are proposing 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.B of this proposed 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 below.

If finalized, the proposed updates to this policy and process would 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 would take SNFs approximately 15 minutes to complete. We believe this data would 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 19.

TABLE 19—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 would increase under this proposal. We estimate that it would 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 would 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 20.

TABLE 20—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 invite public comments on the overall impact of the SNF QRP proposals for FY 2027 displayed in Table 21.

TABLE 21—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 20 and Table 21. 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 fiscal year. As previously finalized, this policy will maintain the overall payback percentage at 60percent 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 22 and Table 23.

TABLE 22—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

TABLE 22—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2026—Continued

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) (%)
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 23—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

TABLE 23—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2026—Continued

Characteristic	Number of facilities	Mean performance score	Mean incentive payment multiplier	Percent of total payment
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.

In Section VII.B of this proposed rule, we are proposing 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 24, 25, and 26. 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 2020–2021 as the baseline period and FY 2022–2023 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 would reduce each SNF's adjusted Federal per diem rate by 2 percent. We would 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 24, 25, and 26.

TABLE 24—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

TABLE 24—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2027—Continued

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) (%)
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 25—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

TABLE 25—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2027—Continued

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)) (%)
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 26—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	34.5323	0.99124	100.00
Urban	9,918	34.7954	0.99142	85.99
Rural	3,571	33.8015	0.99074	14.01
Hospital-based urban **	203	50.0538	1.00382	1.43
Freestanding urban **	9,711	34.4670	0.99115	84.54
Hospital-based rural **	132	47.9675	1.00124	0.30
Freestanding rural **	3,400	32.9848	0.99012	13.63
Urban by region				
New England	663	37.4379	0.99279	5.37
Middle Atlantic	1,375	35.9043	0.99192	19.10
South Atlantic	1,808	34.1598	0.99076	16.47
East North Central	1,820	31.5792	0.98930	10.97
East South Central	508	33.0959	0.99021	2.90
West North Central	786	35.2463	0.99214	3.68
West South Central	1,176	28.6379	0.98735	6.80
Mountain	479	41.0083	0.99608	3.66
Pacific	1,300	41.3149	0.99607	17.04
Outlying	3	42.9683	0.99607	0.00
Rural by region				
New England	98	39.4143	0.99466	0.53
Middle Atlantic	189	34.4778	0.99090	0.94
South Atlantic	430	31.3075	0.98879	1.99
East North Central	774	32.9926	0.99022	3.16
East South Central	446	33.7630	0.99079	1.86
West North Central	794	35.0900	0.99171	1.94
West South Central	579	30.1170	0.98800	2.26
Mountain	180	39.5997	0.99499	0.63

TABLE 26—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2027—Continued

Characteristic	Number of facilities	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Pacific	81	47.4383	1.00148	0.70
Outlying	N/A	N/A	N/A	N/A
Ownership				
Government	769	38.3377	0.99425	3.20
Profit	9,943	32.2324	0.98948	80.89
Non-Profit	2,777	41.7132	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.

8. Alternatives Considered

As described in this section, we estimate that the aggregate impact of the provisions in this proposed rule will result in an increase of approximately $997 million (2.8 percent) in Part A payments to SNFs in FY 2026. This reflects a $997 million (2.8 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 proposals for the SNF QRP, we are proposing to remove four standardized patient assessment data elements. We considered keeping these items but believe that removing them would help reduce burden. With regard to the proposal to amend and codify our reconsideration policy and process, we considered the alternative of leaving the regulatory language unchanged. However, we believe it would be beneficial for SNFs to codify our specific bases for granting a reconsideration request and to clarify the process for requesting an extension to the reconsideration request deadline.

With regard to the proposals 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 27 and 30, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of the proposed rule for FY 2026. Tables 18 and 27 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 15,253 SNFs in our database.

TABLE 27—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2025 SNF PPS FISCAL YEAR TO THE 2026 SNF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	$997 million.
From Whom To Whom?	Federal Government to SNF Medicare Providers.

TABLE 28—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE CHANGES TO THE SNF QRP PROGRAM

Category	Transfers/costs
Estimated Costs to all SNFs for Proposed Changes to the SNF QRP Program	−$2,228,563.12
Estimated Costs to those SNFs requesting an extension to file a request for reconsideration	+2,391.90

TABLE 29—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE FY 2026 SNF VBP PROGRAM

Category	Transfers
Annualized Monetized Transfers	$312.53 million.*

TABLE 29—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE FY 2026 SNF VBP PROGRAM—Continued

Category	Transfers
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 30—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 $519.17 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). Based on the above, we estimate that the overall payments for SNFs under the SNF PPS in FY 2026 are projected to increase by approximately $997 million, or 2.8 percent, compared with those in FY 2025. We estimate that in FY 2026, SNFs in urban and rural areas will experience, on average, a 2.7 percent increase and 3.2 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 5.0 percent. Providers in the urban Pacific region will experience the smallest estimated increase in payments of 1.7 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 proposes updates to the SNF PPS rates contained in the SNF PPS final rule for FY 2025 (89 FR 64048). Based on the above, we estimate that the aggregate impact for FY 2026 will be an increase of $997 million in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 18 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 2024 Report to Congress (available at *https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch6_MedPAC_Report_To_Congress_SEC.pdf*), MedPAC states that Fee-for-Service Medicare accounted for approximately 10 percent of total patient days in freestanding facilities and 17 percent of facility revenue (March 2024 MedPAC Report to Congress, 168) in 2022. As indicated in Table 18, the effect on facilities is projected to be an aggregate positive impact of 2.8 percent for FY 2026. As the overall impact on the industry as a whole, and thus on small entities specifically, does not meet the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed 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 603 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 proposed 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 proposed rule on small entities in general. As indicated in Table 18, the effect on facilities for FY 2026 is projected to be an aggregate positive impact of 2.8 percent. 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 proposed 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 proposed 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 proposed 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 final rule.

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 $227,015.68 ($517.12 × 439 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, if finalized as proposed, is expected to be an E.O. 14192 deregulatory action. We estimate that this rule it would generate $1.93 million in annualized cost savings at a 7 percent discount rate, discounted relative to year 2024, over a perpetual time horizon. approximately $2 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 proposed rule has been reviewed by the Office of Management and Budget.

Stephanie Carlton, Acting Administrator of the Centers for Medicare & Medicaid Services, approved this document on April 8, 2025.

List of Subjects

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 proposes to amend 42 CFR chapter IV 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—
■ a. In paragraph (a) by removing the terms ''Health equity adjustment (HEA) bonus points'', ''Measure performance scaler'', ''Top tier performing SNF'', ''Underserved multiplier'', and ''Underserved population'';
■ b. By revising (c)(2)(i);
■ c. By removing paragraph (e)(3)(iii);
■ d. By revising paragraphs (f)(2) and (3);
■ e. By adding paragraph (f)(6);
■ f. By removing paragraph (k); and
■ g. By redesignating paragraphs (l) through (n) as paragraphs (k) through (m).

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 in 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.

(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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