

*“A **Knowledgeable** and **Compassionate** partner”*



# SNF PPS FY 2026 Proposed Rule

The Facts Beyond the Headlines

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Education



# APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

# CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

# SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.

## DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 1 week

# Learning Objectives

## FY 2026 SNF PPS Proposed Rule

- Understand the proposed rate changes
- Interpret the proposed wage index changes
- Describe the proposed changes to the SNF QRP
- Grasp the proposed updates to the SNF VBP
- Recognize the proposed financial impacts



# Agenda

## FY 2026 SNF PPS Proposed Rule

- FY 2026 Updates to the SNF Payment Rates
- Wage Index Adjustments
- Administrative Level of Care Presumption of Coverage
- Changes in PDPM ICD-10 Code Mappings
- Skilled Nursing Facility Quality Reporting Program (SNF QRP) update
- Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program update
- RFI's
- Financial Impact

# Proposed Rule: Deregulation

- **Unleashing Prosperity Through Deregulation of the Medicare Program - Request for Information:** On January 31, 2025, President Trump issued Executive Order (EO) 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.
- CMS 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.

# Proposed Rule: Deregulation

- CMS is seeking specific information from healthcare providers, researchers, stakeholders, health and drug plans, and other members of the public to inform the development and implementation of strategies to support the goals of the aforementioned EO. Specifically, CMS invites responses on the following topics:
- **Streamline Regulatory Requirements**
  - Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?
  - Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?
  - Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and providers?
- **Opportunities to Reduce Administrative Burden of Reporting and Documentation**
  - What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?
  - Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?
  - Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number.

# Proposed Rule: Deregulation

- **Identification of Duplicative Requirements**

- Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?
- How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?
- How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

- **Additional Recommendations**

- We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.



# Proposed FY 2026 Updated SNF Payment Rates

- **Market Basket Update**

- Every year CMS updates the PPS rate based on changes in the Market Basket (the overall cost of goods and services that contribute to expenditures required to run and maintain a nursing facility). This is then adjusted by a forecast error adjustment and productivity adjustment as applicable.
- For FY 2026, CMS has proposed an update to the Market Basket of 3.0% which has been adjusted upward to 3.6% due to a 0.6% forecast error adjustment (>0.5% threshold).

**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

- \*Forecast data based on second quarter 2023 IHS Global Inc. forecast (2018-based SNF market basket).
- \*\*Actual data Based on the fourth quarter 2024 IHS Global Inc. forecast (2018-based SNF market basket), with historical data through third quarter 2024.
- Finally, CMS has proposed reducing the FY 2026 Market Basket update to **2.8%** due to a 0.8% productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity).
- The overall economic impact of this proposed rule is an estimated increase of **\$997 million in aggregate payments to SNFs during FY 2026.**

# FY 2026 Proposed SNF Payment Rates

FY 2025 Final  
Base Rates

**TABLE 3: FY 2025 Unadjusted Federal Rate Per Diem—URBAN**

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	\$73.25	\$68.18	\$27.35	\$127.68	\$96.33	\$114.34

**TABLE 4: FY 2025 Unadjusted Federal Rate Per Diem—RURAL**

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	\$83.50	\$76.69	\$34.46	\$121.99	\$92.03	\$116.46

**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

FY 2026 Proposed  
Base Rates

# FY 2026 Proposed Updates to the SNF Payment Rates

Urban Case Mix  
Adjusted Rates and  
Associated indexes

PT
\$75.42

X

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	-	-



# FY 2026 Proposed Updates to the SNF Payment Rates

Rural Case Mix  
Adjusted Rates and  
Associated indexes

**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	-	-



# Proposed FY 2026 Wage Index Adjustments

- **Wage Index**

- CMS is required to 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, CMS has used hospital inpatient wage data in developing a wage index to be applied to SNFs. CMS will continue this practice for FY 2026.
- CMS continues 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.
- The proposed wage index data for FY 2026 can be found at:  
<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/wage-index>
- The applicable SNF PPS wage index is assigned to the labor related portion of the rate using the area hospital labor market.
- On July 21, 2023, OMB issued Bulletin No. 23-01 which updates CBSA data from Bulletin No. 20-01 based upon the 2020 Standards for Delineating Core Based Statistical Areas.

# Proposed FY 2026 Wage Index Adjustments

- **Wage Index (cont.)**

- The revisions OMB published on July 21, 2023 contained a number of significant changes. For example, under the proposed revised OMB delineations, there would be new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would split apart.
- OMB has not published further delineation revisions since OMB Bulletin No. 23-01. Therefore, for FY 2026, CMSA is proposing to maintain the current CBSA delineations.
- CMS recognizes that changes to the wage index have the potential to create instability and significant negative impacts on certain providers even when labor market areas do not change. In addition, year-to-year fluctuations in an area's wage index can occur due to external factors beyond a provider's control.
- In the FY 2023 final rule, CMS finalized 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. **Subsequent year adjustments will be based on any applicable 5% cap from the prior year.**
- Additionally, CMS 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.

## Proposed FY 2026 Wage Index changes

# FY 2026 Wage Index Impact

- 48% of Urban counties will have a negative adjustment to their wage index
- 10% of Urban counties will have their wage index capped at 5%
- 56% of states will have a negative adjustment to their rural wage indexes
- 4% of states will have their rural wage indexes capped at 5%

# Proposed FY 2025 Wage Index Adjustments

- **Labor Related Share of the Rate**

- The wage index adjusts the labor related portion of the case mix adjusted base rate.
- CMS defines the labor-related share (LRS) as those expenses that are labor-intensive and vary with, or are influenced by, the local labor market. Each year, CMS calculates a revised labor related share based on the relative importance of labor-related cost categories in the input price index.
- For FY 2026, CMS has proposed a labor-related share to reflect the the fourth quarter 2024 IHS Global Inc. forecast of the 2022-based SNF market basket cost categories that they believe are labor-intensive and vary with, or are influenced by, the local labor market. These are:
  - (1) Wages and Salaries (including allocated contract labor costs as described above);
  - (2) Employee Benefits (including allocated contract labor costs as described above);
  - (3) Professional fees: Labor-related;
  - (4) Administrative and Facilities Support Services;
  - (5) Installation, Maintenance, and Repair Services;
  - (6) All Other: Labor-Related Services; and
  - (7) Capital-related expenses



# Wage Index Adjustments

## Proposed FY 2026 Labor Related Share of the PPS Rate

**TABLE 7: Labor-Related Share, FY 2025 and FY 2026**

	Relative importance, labor-related share, FY 2025 24:2 forecast <sup>1</sup>	Proposed Relative importance, labor-related share, FY 2026 24:4 forecast <sup>2</sup>
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 RD)	3.2	3.1
Total	72.0	71.9

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

<sup>2</sup>. 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.

# Proposed FY 2026 Wage Index Adjustments

## Proposed FY 2026 PDPM Variable Perdiem Adjustment Rate Table

**HIPPS: NHNC1**



County		CBSA	FY 26 WI	FY 2025 WI	26/25 Diff	5% Cap
CO, CLEAR CREEK County		Urban	1.0118	0.9756	3.71%	
26 Non-CM	26 Labor	26 N-Labor	26 U Rate	26 WI Rate	26 ADR	26 Total \$\$
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 1,119.48	\$ 1,119.48	\$ 1,119.48
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 1,119.48	\$ 1,119.48	\$ 2,238.96
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 1,119.48	\$ 1,119.48	\$ 3,358.44
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 1,032.45	\$ 4,129.81
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 980.24	\$ 4,901.18
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 945.43	\$ 5,672.55
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 920.56	\$ 6,443.92
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 901.91	\$ 7,215.29
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 887.41	\$ 7,986.66
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 875.80	\$ 8,758.03
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 866.31	\$ 9,529.40
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 858.40	\$ 10,300.77
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 851.70	\$ 11,072.14
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 845.97	\$ 11,843.51
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 771.37	\$ 840.99	\$ 12,614.88

BRR

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FY 205 WI Rate

FY 2025 ADR

FY 2025 Total \$\$

2025-2026 WI Daily Rate Diff:

2025-2026 Avg. DR Diff:

2025-2026 Daily Tot. \$\$ Diff:

2025-2026 % Rate Change

\$ 1,059.14	\$ 1,059.14	\$ 1,059.14	\$ 60.34	\$ 60.34	\$ 60.34	5.70%
\$ 1,059.14	\$ 1,059.14	\$ 2,118.28	\$ 60.34	\$ 60.34	\$ 120.68	5.70%
\$ 1,059.14	\$ 1,059.14	\$ 3,177.42	\$ 60.34	\$ 60.34	\$ 181.02	5.70%
\$ 729.81	\$ 976.81	\$ 3,907.23	\$ 41.56	\$ 55.65	\$ 222.58	5.69%
\$ 729.81	\$ 927.41	\$ 4,637.04	\$ 41.56	\$ 52.83	\$ 264.14	5.69%
\$ 729.81	\$ 894.48	\$ 5,366.85	\$ 41.56	\$ 50.95	\$ 305.70	5.69%
\$ 729.81	\$ 870.95	\$ 6,096.66	\$ 41.56	\$ 49.61	\$ 347.26	5.69%
\$ 729.81	\$ 853.31	\$ 6,826.47	\$ 41.56	\$ 48.60	\$ 388.82	5.69%
\$ 729.81	\$ 839.59	\$ 7,556.28	\$ 41.56	\$ 47.82	\$ 430.38	5.69%
\$ 729.81	\$ 828.61	\$ 8,286.09	\$ 41.56	\$ 47.19	\$ 471.94	5.69%
\$ 729.81	\$ 819.63	\$ 9,015.90	\$ 41.56	\$ 46.68	\$ 513.50	5.69%
\$ 729.81	\$ 812.14	\$ 9,745.71	\$ 41.56	\$ 46.26	\$ 555.06	5.69%
\$ 729.81	\$ 805.81	\$ 10,475.52	\$ 41.56	\$ 45.89	\$ 596.62	5.69%
\$ 729.81	\$ 800.38	\$ 11,205.33	\$ 41.56	\$ 45.58	\$ 638.18	5.69%
\$ 729.81	\$ 795.68	\$ 11,935.14	\$ 41.56	\$ 45.32	\$ 679.74	5.69%

# Proposed FY 2026 Wage Index Adjustments

## Proposed FY 2026 PDPM

### Variable Perdiem Adjustment Rate Table

## HIPPS: NHNC1



County		CBSA	FY 26 WI	FY 2025 WI	26/25 Diff	5% Cap							
MD, FREDERICK County		Urban	0.9768	0.9876	-1.09%								
26 Non-CM	26 Labor	26 N-Labor	26 U Rate	26 WI Rate	26 ADR	26 Total \$\$	FY 205 WI Rate	FY 2025 ADR	FY 2025 Total \$\$	2025-2026 WI Daily Rate Diff:	2025-2026 Avg. DR Diff:	2025-2026 Daily Tot. \$\$ Diff:	2025-2026 % Rate Change
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 1,091.54	\$ 1,091.54	\$ 1,091.54	\$ 1,068.45	\$ 1,068.45	\$ 1,068.45	\$ 23.09	\$ 23.09	\$ 23.09	2.16%
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 1,091.54	\$ 1,091.54	\$ 2,183.08	\$ 1,068.45	\$ 1,068.45	\$ 2,136.90	\$ 23.09	\$ 23.09	\$ 46.18	2.16%
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 1,091.54	\$ 1,091.54	\$ 3,274.62	\$ 1,068.45	\$ 1,068.45	\$ 3,205.35	\$ 23.09	\$ 23.09	\$ 69.27	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 1,006.69	\$ 4,026.74	\$ 736.23	\$ 985.40	\$ 3,941.58	\$ 15.89	\$ 21.29	\$ 85.16	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 955.77	\$ 4,778.86	\$ 736.23	\$ 935.56	\$ 4,677.81	\$ 15.89	\$ 20.21	\$ 101.05	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 921.83	\$ 5,530.98	\$ 736.23	\$ 902.34	\$ 5,414.04	\$ 15.89	\$ 19.49	\$ 116.94	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 897.59	\$ 6,283.10	\$ 736.23	\$ 878.61	\$ 6,150.27	\$ 15.89	\$ 18.98	\$ 132.83	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 879.40	\$ 7,035.22	\$ 736.23	\$ 860.81	\$ 6,886.50	\$ 15.89	\$ 18.59	\$ 148.72	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 865.26	\$ 7,787.34	\$ 736.23	\$ 846.97	\$ 7,622.73	\$ 15.89	\$ 18.29	\$ 164.61	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 853.95	\$ 8,539.46	\$ 736.23	\$ 835.90	\$ 8,358.96	\$ 15.89	\$ 18.05	\$ 180.50	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 844.69	\$ 9,291.58	\$ 736.23	\$ 826.84	\$ 9,095.19	\$ 15.89	\$ 17.85	\$ 196.39	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 836.98	\$ 10,043.70	\$ 736.23	\$ 819.29	\$ 9,831.42	\$ 15.89	\$ 17.69	\$ 212.28	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 830.45	\$ 10,795.82	\$ 736.23	\$ 812.90	\$ 10,567.65	\$ 15.89	\$ 17.55	\$ 228.17	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 824.85	\$ 11,547.94	\$ 736.23	\$ 807.42	\$ 11,303.88	\$ 15.89	\$ 17.43	\$ 244.06	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 820.00	\$ 12,300.06	\$ 736.23	\$ 802.67	\$ 12,040.11	\$ 15.89	\$ 17.33	\$ 259.95	2.16%
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 752.12	\$ 815.76	\$ 13,052.18	\$ 736.23	\$ 798.52	\$ 12,776.34	\$ 15.89	\$ 17.24	\$ 275.84	2.16%



# Proposed FY 2026 Wage Index Adjustments

## Proposed FY 2026 PDPM

### Variable Perdiem Adjustment Rate Table

## HIPPS: NHNC1



County		CBSA	FY 26 WI	FY 2025 WI	26/25 Diff	5% Cap
AL, RUSSELL County		Urban	0.7523	0.8206	-8.32%	0.7796
26 Non-CM	26 Labor	26 N-Labor	26 U Rate	26 WI Rate	26 ADR	26 Total \$\$
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 934.13	\$ 934.13	\$ 934.13
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 934.13	\$ 934.13	\$ 1,868.26
\$ 117.73	\$ 798.13	\$ 311.93	\$ 1,110.06	\$ 934.13	\$ 934.13	\$ 2,802.39
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 861.51	\$ 3,446.04
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 817.94	\$ 4,089.69
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 788.89	\$ 4,733.34
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 768.14	\$ 5,376.99
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 752.58	\$ 6,020.64
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 740.48	\$ 6,664.29
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 730.79	\$ 7,307.94
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 722.87	\$ 7,951.59
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 716.27	\$ 8,595.24
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 710.68	\$ 9,238.89
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 705.90	\$ 9,882.54
\$ 117.73	\$ 549.95	\$ 214.93	\$ 764.88	\$ 643.65	\$ 701.75	\$ 10,526.19

FY 205 WI Rate	FY 2025 ADR	FY 2025 Total \$\$	2025-2026 WI Daily Rate Diff:	2025-2026 Avg. DR Diff:	2025-2026 Daily Tot. \$\$ Diff:	2025-2026 % Rate Change
\$ 938.83	\$ 938.83	\$ 938.83	\$ (4.70)	\$ (4.70)	\$ (4.70)	-0.50%
\$ 938.83	\$ 938.83	\$ 1,877.66	\$ (4.70)	\$ (4.70)	\$ (9.40)	-0.50%
\$ 938.83	\$ 938.83	\$ 2,816.49	\$ (4.70)	\$ (4.70)	\$ (14.10)	-0.50%
\$ 646.91	\$ 865.85	\$ 3,463.40	\$ (3.26)	\$ (4.34)	\$ (17.36)	-0.50%
\$ 646.91	\$ 822.06	\$ 4,110.31	\$ (3.26)	\$ (4.12)	\$ (20.62)	-0.50%
\$ 646.91	\$ 792.87	\$ 4,757.22	\$ (3.26)	\$ (3.98)	\$ (23.88)	-0.50%
\$ 646.91	\$ 772.02	\$ 5,404.13	\$ (3.26)	\$ (3.88)	\$ (27.14)	-0.50%
\$ 646.91	\$ 756.38	\$ 6,051.04	\$ (3.26)	\$ (3.80)	\$ (30.40)	-0.50%
\$ 646.91	\$ 744.22	\$ 6,697.95	\$ (3.26)	\$ (3.74)	\$ (33.66)	-0.50%
\$ 646.91	\$ 734.49	\$ 7,344.86	\$ (3.26)	\$ (3.69)	\$ (36.92)	-0.50%
\$ 646.91	\$ 726.52	\$ 7,991.77	\$ (3.26)	\$ (3.65)	\$ (40.18)	-0.50%
\$ 646.91	\$ 719.89	\$ 8,638.68	\$ (3.26)	\$ (3.62)	\$ (43.44)	-0.50%
\$ 646.91	\$ 714.28	\$ 9,285.59	\$ (3.26)	\$ (3.59)	\$ (46.70)	-0.50%
\$ 646.91	\$ 709.46	\$ 9,932.50	\$ (3.26)	\$ (3.57)	\$ (49.96)	-0.50%
\$ 646.91	\$ 705.29	\$ 10,579.41	\$ (3.26)	\$ (3.55)	\$ (53.22)	-0.50%



# Administrative Level of Care Presumption of Coverage

- **Presumption of Coverage**

- Annually CMS designates those specific classifiers under the case-mix classification system that represent the required SNF level of care. 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.
- This presumption recognizes the strong likelihood that those beneficiaries who are 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.
- 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.
- See [CMS Pub 100-2 Ch. 8](#) for detailed explanation of the Administrative level of Care Presumption of Coverage.
- See the [CMS PDPM website](#) for a detailed Administrative Level of Care Presumption of Coverage FAQ.

# Administrative Level of Care Presumption of Coverage

- **Presumption of Coverage (Cont.)**

- For services furnished on or after October 1, 2019, the following are the designated case-mix classifiers under the Patient Driven Payment Model (PDPM) relative to the administrative presumption of coverage:
  - **Nursing** groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
  - **PT and OT** groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
  - **SLP** groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
  - **NTA** component's uppermost (12+) comorbidity group.

# Proposed FY 2026 Clinical Category Changes for New ICD-10 Codes

- Each year, CMS reviews the clinical category assigned to new ICD-10 diagnosis codes and proposes changing the assignment to another clinical category if warranted.
- This year, CMS is proposing changing the clinical category assignment for the following thirty-four new ICD-10 codes that were effective on October 1, 2024
- CMS is inviting comments on these proposed changes to the PDPM ICD-10 mappings.

**Type 1 diabetes mellitus is an autoimmune condition characterized by insulin deficiency, leading to chronic hyperglycemia.**

## Type 1 diabetes mellitus

- 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, CMS does not believe these codes would serve appropriately as the primary diagnoses for a Part A-covered SNF stay.
- **As a result, CMS is proposing to change the mapping of these codes from “Medical Management” to the clinical category of “Return to Provider”.**



**Hypoglycemia, defined as blood glucose levels below 70 mg/dL, is a common complication in individuals with diabetes mellitus or other metabolic disorders. Codes**

## Hypoglycemia

- **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, CMS does not believe these codes would serve appropriately as the primary diagnoses for a Part A-covered SNF stay.
- **As a result, CMS is proposing to change the mapping of these codes from “Medical Management” to the clinical category of “Return to Provider”.**

**Obesity is a chronic, relapsing, multifactorial disease characterized by excessive adipose tissue accumulation that increases the risk of metabolic, cardiovascular, and musculoskeletal disorders.**

## Obesity

- **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, CMS does 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”.**



**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.

## **Anorexia Nervosa, Restricting Type**

- **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, CMS does not believe this code would serve appropriately as the primary diagnosis for a Part A-covered SNF stay.
- **As a result, CMS is proposing to change the mapping of this code from “Medical Management” to the clinical category of “Return to Provider”.**



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..

## Anorexia Nervosa, Binge Eating/Purging Type

- **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, CMS does not believe these codes would serve appropriately as the primary diagnoses for a Part A-covered SNF stay.
- As a result, CMS is proposing to change the mapping of these codes from “Medical Management” to the clinical category of “Return to Provider”.

**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.**

## Bulimia Nervosa

- **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, CMS does not believe these codes would serve appropriately as the primary diagnoses for a Part A-covered SNF stay.
- **As a result, CMS is proposing to change the mapping of these codes from “Medical Management” to the clinical category of “Return to Provider”.**

Binge eating disorder is characterized by recurrent episodes of binge eating without compensatory behaviors such as purging, fasting, excessive exercise, etc.

## Binge Eating Disorder

- **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, CMS does not believe these codes would serve appropriately as the primary diagnoses for a Part A-covered SNF stay.
- **As a result, CMS is proposing to change the mapping of these codes from “Medical Management” to the clinical category of “Return to Provider”.**



## 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”.**



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.

## Serotonin Syndrome

- **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, CMS does not believe this code would serve appropriately as the primary diagnosis for a Part A-covered SNF stay.
- **As a result, CMS is proposing to change the mapping of this code from “Acute Neurologic” to the clinical category of “Medical Management”.**

# Proposed SNF QRP Updates

## Current SNF QRP Measures:

In this proposed rule, CMS is not proposing to adopt any new measures for the SNF QRP.

**TABLE 11: Quality Measures Currently Adopted for the SNF QRP**

Short Name	Measure Name & Data Source
<b>Resident Assessment Instrument Minimum Data Set (Assessment-Based)</b>	
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
<b>Claims-Based</b>	
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
<b>National Healthcare Safety Network</b>	
HCP COVID19 Vaccine	COVID19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

# Proposed SNF QRP Updates – Removal of MDS Items

- In this proposed rule, CMS is proposing to remove these four standardized patient assessment data elements under the SDOH category acknowledging the burden associated with these items at this time.
- 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 this 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 this proposal, these items would not be required to meet the SNF QRP requirements beginning with the FY 2027 SNF QRP.
- PRA Notice: <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing-items/cms-10387>



# Proposed SNF QRP Updates – Proposals to Amend the Reconsideration Request Policy and Process

- Proposal to clarify the guidance to allow SNFs to request an extension to file a request for reconsideration
  - **CMS is proposing** to remove the term “extenuating circumstances” as used currently in the reconsideration policy and replace it with “extraordinary circumstances.” Specifically, CMS is proposing 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).
  - **CMS is proposing** to amend the reconsideration policy as codified 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 the SNF was affected by an extraordinary circumstance beyond the control of the SNF (for example, a natural or man-made disaster). **CMS is further proposing** that the SNF must submit its request for an extension to file a reconsideration request to CMS via email to [SNFQRPreconsiderations@cms.hhs.gov](mailto:SNFQRPreconsiderations@cms.hhs.gov) no later than 30 calendar days from the date of the written notification of noncompliance. **CMS further proposes** 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.



# Proposed SNF QRP Updates – Proposals to Amend the Reconsideration Request Policy and Process

- CMS is proposing to modify our reconsideration policy to provide that they 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.
- CMS will consider full compliance with the SNF QRP requirements to include CMS granting an exception or extension to SNF QRP reporting requirements under the ECE policy. 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.

# Proposed SNF QRP Updates – Measures Under Consideration RFI

- CMS is 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. CMS will prioritize outcome measures that are evidence-based and meet the set of principles set forth in the FY 2024 SNF PPS proposed rule for selecting and prioritizing SNF QRP measures, identifying measurement gaps, and suitable measures for filling these gaps.

TABLE 12: Future Measure Concepts Under Consideration for the SNF QRP

Quality Measure Concepts
Interoperability
Well-being
Nutrition
Delirium

- **Interoperability:** We are seeking input on the quality measure concept of interoperability, focusing on information technology systems’ readiness and capabilities in the SNF setting.
- Interoperability is 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. Also, 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.

# Proposed SNF QRP Updates – Measures Under Consideration

## RFI

- **Well-Being:** CMS is seeking input on a quality measure concept of well-being for future quality measures. CMS is 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 while emphasizing preventative care to proactively address potential health issues. This comprehensive approach emphasizes person-centered care by promoting well-being of residents. CMS is requesting 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.
- **Nutrition:** CMS is 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. CMS is requesting 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.

# Proposed SNF QRP Updates – Measures Under Consideration

## RFI

- **Delirium:** CMS is 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. CMS is requesting 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 that may be associated with underlying symptoms or conditions.



# Proposed SNF QRP Updates – Revision of the Final Data Submission Deadline from 4.5 months to 45 Days – (RFI)

- CMS is requesting feedback on a potential future reduction of the SNF QRP data submission deadline from 4.5 months to 45 days that is under consideration.
- Specifically, CMS is 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.
- CMS intends to use this input to inform program improvement efforts.

# Proposed SNF QRP Updates – Advancing Digital Quality Measurement in the SNF QRP – (RFI)

- Solicitation for Comment: CMS is seeking 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?
  - Does your SNF submit resident assessment data to CMS directly from your health IT system without the assistance of a third-party intermediary?
  - Are there any challenges with your current electronic devices (for example, tablets, smartphones, computers) that hinder your ability to easily exchange information across systems?
  - 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 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 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

# Proposed SNF QRP Updates – Advancing Digital Quality Measurement in the SNF QRP – (RFI)

- Is your facility using technology that utilizes APIs based on the FHIR® standard to enable electronic data sharing?
- 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 benefits or challenges have you experienced with implementing technology that uses FHIR® -based APIs?
- 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?
- Would your SNF and/or vendors be interested in participating in testing to explore options for transmission of assessments, for example testing the transmission of a FHIR® -based assessment to CMS?
- How could the Trusted Exchange Framework and Common Agreement™ (TEFCA™) support CMS quality programs' adoption of FHIR® -based assessment submissions consistent with the FHIR® Roadmap?
- 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?

# Proposed SNF VBP Updates – Proposal to Remove the Health Equity Adjustment Beginning with the FY 2027 Program Year

- CMS is proposing to remove the Health Equity Adjustment because it is believed 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.
- CMS 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.



# Current SNF VBP Measures

**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

Program Performance Standards (achievement threshold and benchmarks) have been updated.

**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

**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

Skilled Nursing Facility Value-Based Purchasing Program FY 2026 Program Year Fact Sheet

# Proposed SNF VBP Updates – Proposed Application of the SNF VBP Scoring Methodology to the SNF WS PPR Measure Beginning With the FY 2028 Program Year

- CMS is proposing to apply the previously finalized scoring methodology 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.



# Proposed SNF VBP Updates – Proposal to Adopt a SNF VBP Program Reconsideration Process

- Beginning with the FY 2027 SNF VBP program year, CMS is 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.
- CMS is proposing that SNFs would be able to request this additional reconsideration only if they first submit a valid review and correction request 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.
- 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.



# Estimated Financial Impact of SNF PPS FY 2026

**TABLE 18: Impact to the SNF PPS for FY 2026**

Impact Categories	Number of Facilities	Update Wage Data	Total Change
<b>Group</b>			
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%
<b>Urban by region</b>			
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%
<b>Rural by region</b>			
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%
<b>Ownership</b>			
For profit	10,920	-0.1%	2.7%
Non-profit	3,304	0.3%	3.1%
Government	1,029	0.3%	3.1%

# Proposed SNF QRP Financial Impact

**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

# Estimated SNF VBP Financial Impact 2026

**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
<b>Group</b>				
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
<b>Urban by region</b>				
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
<b>Rural by region</b>				
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
<b>Ownership</b>				
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



# Estimated SNF VBP Financial Impact 2027

**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
<b>Group</b>				
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
<b>Urban by region</b>				
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
<b>Rural by region</b>				
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
Pacific	81	47.4383	1.00148	0.70
Outlying	N/A	N/A	N/A	N/A
<b>Ownership</b>				
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

# Proposed SNF VBP Updates – Comment Period

To be assured consideration, comments must be received at one of the addresses provided below, by June 30th, 2025. Comments, must be submitted in one of the following three ways (please choose only one of the ways listed):

- **Electronically.** You may submit electronic comments on this regulation to <http://www.regulations.gov> Follow the "Submit a comment" instructions.
- **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-18272-P,
  - P.O. Box 8016,
  - Baltimore, MD 21244-8016.
- **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-18272-P,
  - Mail Stop C4-26-05,
  - 7500 Security Boulevard,
  - Baltimore, MD 21244-1850.

# QUESTIONS?



# Find Out More

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