AHCA Summary of FY26 Skilled Nursing Facility Prospective Payment System Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) fiscal year (FY) 2026 update.

In the FY26 NPRM, **CMS has proposed a net market basket update of 2.8%** - based on the proposed SNF market basket of 3.0%, plus a 0.6% market basket forecast error adjustment, and a negative 0.8% productivity adjustment. Of note, the proposed net market basket and underlying figures, below, all typically change between the proposed rule and the final rule based on more current data. Additionally, this is AHCA's preliminary analysis of the proposed rule. Additional information will be provided as AHCA continues its analysis of CMS' proposals.

The table below shows the components of the current proposed rule versus the last two year's final rules.

Market Basket and Adjustments	2024 Final	2025 Final	2026 Proposed
Unadjusted Market Basket Index	3.00%	3.00%	**3.00%**
Forecast Error	3.60%	1.70%	**0.60%**
Productivity Adjustment	-0.20%	-0.50%	**-0.80%**
Net Market Basket Index in the Proposed Rule	4.00%	4.20%	**2.80%**

CMS states that the proposed net market basket update will increase Medicare SNF payments by approximately $997 Million in FY26. SNF Value-Based Purchasing (VBP) reductions for certain SNFs subject to the net reduction in payments under the SNF VBP adjustments are estimated to total $208.36 million in FY26.

For FY26, there are no geographic reclassifications because OMB has not published revisions since last year's rule. This stability in CBSAs eliminates the need to apply the 5% cap on decreases to a provider's wage index caused by a reclassification.

For comparison purposes, the final FY25 and proposed FY26 base rates following standard annual updates are shown in the payment provision highlights. The Forecast Error Adjustment is shown in the payment provision highlights.

The following pages are preliminary highlights followed by a detailed summary of each section.

Other Preliminary Highlights

Administrative Updates

- CMS is proposing several changes to the PDPM ICD-10 code mappings for reporting during a Part A SNF stay.

SNF Quality Reporting Program (QRP)

- CMS is proposing to remove four standardized patient assessment data elements under the Social Determinant of Health (SDOH) category – including one item for "living situation," two items for "food," and one item for "utilities."
- CMS is proposing to amend the reconsideration policy and process. Specifically, CMS is proposing to allow SNFs to request an extension to file a request for reconsideration and to update the bases on which CMS can grant a reconsideration request.
- CMS also seeks input on several RFIs, specifically: 1) future measure concepts on the topics of delirium, interoperability, nutrition, and well-being; 2) revisions to the current data submission deadlines for assessment data, which would allow CMS to provide SNFs with more timely quality data; and 3) advancing digital quality measurement and the use of Fast Healthcare Interoperability Resources® in the SNF QRP.
- CMS is also seeking feedback on future measures for the SNF QRP with a Request for Information (RFI) on quality measure concepts under consideration for future years.

SNF Value-Based Purchasing (VBP)

- There are no proposed changes proposed for the upcoming FY26 program year.
- The overall economic impact is an estimated reduction of $208.36 million in aggregate payments to SNFs during FY26 and $207.99 million during FY27.
- CMS proposes to remove the SNF VBP Health Equity Adjustment that was set to begin in the FY27 program year.
    a. As a refresher, this adjustment would provide bonus points to high-performing facilities that care for a high proportion (20% or higher) of Medicare and Medicaid dual eligible beneficiaries. To accommodate the additional bonus points and not redirect money away from other SNFs, CMS would increase the payback percentage to 66% from 60%.
- CMS proposes the performance standards for the FY28 and FY29 program years. Additionally, they propose to adopt a scoring methodology similar to other measures for the new SNF Within-Stay Potentially Preventive Readmission (SNF WS PPR) measure set to begin with the FY28 program year.
- CMS proposes to adopt an additional reconsideration process that will allow SNFs to appeal CMS' initial decisions for Review and Correction (R&C) requests prior to any affected data being publicly available.

Proposed Rule Detailed Summary

Introduction

Section 1888(e) of the Social Security Act established the SNF PPS for Medicare Part A services for cost reporting periods beginning on or after July 1, 1998, using base year cost data from FY95. The Act requires a detailed formula for calculating base payment rates and does not provide for the use of any alternative methodology. CMS has incorporated a number of elements into the SNF PPS, such as 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. In addition, the Act requires CMS to Publish the payment rates for each new FY through the Federal Register, and to do so before August 1 that precedes the start of the new Fiscal Year.

A. Payment Provision Highlights

The final FY25 and proposed FY26 base rates are shown below. Like the net market basket, FY26 Tables 3 and 4 will change in the final rule due to more current underlying data:

FY25 Final Rule – Tables 3 & 4

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

***NOTE:** "Unadjusted" means the labor adjustments have not been applied to these rates.

FY26 Proposed Rule – Tables 3 & 4

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

***NOTE:** "Unadjusted" means the labor adjustments have not been applied to these rates.

B. Forecast Error

The forecast error statutory provision is only found in the SNF payment system. Under the forecast error statutory provision, CMS compares a projected market basket update with the actual market basket update using prior year data. For this proposed rule, CMS looks at the difference between the actual and forecasted MBI for FY24.

Intended to account for inflation, the forecast increases the market basket when the projected market basket is 0.5% less than the actual market basket. Conversely, when the forecast decreases the market basket when the projected market basket is 0.5% more than the actual market basket. If the variance in either direction is less than 0.5%, no forecast error is incurred.

For this year, the forecast error had a positive impact on the net market basket figure. Table 2 from the proposed rule is shown below as an overview.

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

For FY26, the .6% difference between forecasted and actual for FY24 was added to the FY26 unadjusted market basket of 3.0%, resulting in 3.6%. This was reduced by the productivity adjustment of 0.8% to arrive at the Net proposed MBI for FY26 of 2.8%.

C. Market Basket

The impact of the SNF PPS FY26 rule is 2.8%. However, because of the wage index, the impact will vary based on a provider's classification as Urban or Rural. CMS estimates that impact in Table 18 from the proposed rule below.

TABLE 18: Impact to the SNF PPS for FY26

Group	Number of Facilities	Update Wage Data	Total Change
Total	15,253	0.00%	2.80%
Urban	11,054	-0.10%	2.70%
Rural	4,199	0.40%	3.20%

Also, CMS will revise the Market Basket (MBI) calculation before the publication of the Final Rule in late summer. The forecast error in the FY26 MBI includes estimates for one quarter. Updated information will be available when the CMS Summary Web Table is updated.

D. Productivity Adjustment

CMS is required under the Social Security Act to reduce the Skilled Nursing Facility (SNF) market basket percentage by the productivity adjustment. This adjustment reflects the 10-year moving average of changes in annual economy-wide private nonfarm business total factor productivity (TFP). The purpose is to ensure that annual updates to SNF payment rates also account for increases in provider productivity. A complete description of the TFP projection methodology is available.

E. Wage Index

Since the start of SNF PPS, CMS has used hospital inpatient wage data, without SNF-specific wage data, in developing a wage index to be applied to SNFs. That practice continues in the FY26 proposed rule. CMS continues to use hospital data as a surrogate for SNF data and has no plans to use SNF data due to the resources required to collect and audit the information. This is a recurring area of member feedback that AHCA will again highlight in comments to CMS.

Individual providers are assigned a CBSA, which impacts the facility specific rate. Changes year-over-year can cause fluctuations. For FY26 there are no CBSA changes as the OMB did not publish an update.

In FY23, CMS instituted a permanent 5% cap on decreases to a provider's wage index from its wage index in the prior year, regardless of the reason for the decline. This would be available to providers in FY26, however, there were no OMB updates to CBSA delineations published.

The wage index applicable to FY26 is set forth in Table A available on the CMS website.

F. Labor Related Portion of the PPS Rate

CMS calculates the labor-related portion of the PPS rate from the SNF market basket, and it approximates this share after considering historical and projected price changes between the base year and FY26. The different cost categories in the market basket do not necessarily change at

the same rate, and CMS calculations capture these changes. Accordingly, the labor portion of the rate more closely reflects the cost share weights for FY26 than the base year weights from the SNF market basket. Then, the Labor Related Portion is multiplied by the wage index to arrive at a location specific labor portion. For FY26, CMS reduced the labor portion from 72% to 71.9%. This means that the labor portion of the rate will closely approximate the FY25 Final Rule.

G. Consolidated Billing

No changes are proposed; however, CMS continued the practice of soliciting public comments identifying HCPCS codes in any of five service categories (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices, and blood clotting factors) that represent recent medical advances that might meet the criteria for exclusion. AHCA will work with the membership to identify specific HCPCS codes to request they be excluded.

H. Technical Updates to PDPM ICD-10 Mapping

CMS implemented the Patient-Driven Payment Model (PDPM) in FY20 to improve payment accuracy and appropriateness based on patient needs rather than the volume of services provided.

PDPM utilizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) codes in several ways, including using the person's primary diagnosis to assign patients to clinical categories.

CMS is proposing several changes to the PDPM ICD-10 code mappings to allow providers to provide more accurate, consistent, and appropriate primary diagnoses that meet the criteria for skilled intervention during a Part A SNF stay. In this proposed rule, CMS proposes several changes to the PDPM ICD-10 code mappings to maintain consistency with the latest ICD-10 coding guidance.

Each year, the clinical categories assigned to new ICD–10 diagnosis codes are reviewed and they are added, removed, or the assignment is changed to another clinical category if warranted. This year, CMS is proposing to change the clinical category assignment for 34 new ICD-10 codes that were effective 10/1/2024. The diagnoses categories include:

a) Diabetes Mellitus
b) Hypoglycemia
c) Obesity
d) Anorexia Nervosa, Restricting Type
e) Anorexia Nervosa, Binge Eating/Purging Type
f) Bulimia Nervosa
g) Binge Eating Disorder
h) Pica and Rumination Disorder, and
i) Serotonin Syndrome

All codes in 'a' through 'h' in the list above are being mapped to "Return to Provider" because they are not considered a specific enough diagnosis for Part A covered stay clinical category assignment. The last diagnosis group listed above, 'Serotonin Syndrome' is proposed to be revised from "Acute Neurologic" to the clinical category of "Medical Management.'

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

The SNF QRP applied to post-acute patients and is part of the IMPACT act requires standardized measures across post-acute providers and levies a two-percentage point reduction in their annual update for SNFs that do not meet reporting requirements.

The SNF QRP is a pay-for-reporting program. SNFs that do not meet reporting requirements are subject to a 2-percentage point reduction in their Annual Payment Update (APU). Additionally, CMS publicly reports each SNF's performance on measures adopted into the SNF QRP on the Care Compare website.

Proposed Updates to the SNF QRP:

- CMS is not proposing any changes to current SNF Quality Measures.

- Proposal to remove Four Standardized Patient Assessment Data Elements beginning with the FY27 SNF QRP
    - CMS is proposing to remove four items previously adopted as standardized patient assessment data elements under the social determinants of health category beginning with the FY 2027 SNF QRP: one item for Living Situation (R0310), two items for Food (R0320A and R0320B), and one item for Utilities (R0330) beginning with residents admitted on or after October 1, 2025, as previously finalized. The rationale is that CMS acknowledges the burden associated with these items and instead is changing focus towards the workflow for these data elements being part of a low burden interoperable electronic system leveraging health information technology (HIT) advances.

- Proposals to Amend the Reconsideration Request Policy and Process
    - In the FY16 SNF PPS final rule CMS finalized (and subsequently updated) 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% for the applicable fiscal year as required by the Act. In this proposed rule, CMS notes the Agency has become aware there are inconsistencies in the preamble and regulation text regarding SNF requests for reconsideration. On this basis, in this proposed rule, CMS seek to clarify the following areas.

- Proposal 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 proposes 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, CMS also proposes to incorporate its prior explanation regarding the meaning of extraordinary circumstances, as set forth in the FY16 SNF PPS final rule as part of the Extraordinary Circumstance Exception and Extension (ECE) policy.

CMS recognizes that current policy does not clearly demarcate deadlines and proposes to amend the 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). CMS proposes that the SNF must submit its request for an extension to file a reconsideration request to CMS via email 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.

CMS further proposes that CMS 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. CMS proposes 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.

- Proposal to Update the Bases on Which CMS Can Grant a Reconsideration Request
    - CMS indicates a belief that it would be beneficial for SNFs to codify the specific bases for the Agency granting a reconsideration request in the regulation at § 413.360(d). CMS proposes to modify our reconsideration policy to provide that the Agency 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 would 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 at § 413.360(c). However, to demonstrate full compliance with the ECE policy, the SNF would need to comply with the ECE policy's requirements, including the specific scope of the exception or extension as granted by CMS.

- SNF QRP Measure Concepts Under Consideration for Future Years – Request for Information (RFI): Interoperability, Well-Being, Nutrition & Delirium
    - CMS seeks input on the importance, relevance, appropriateness, and applicability of four quality measure concepts under consideration related to interoperability, well-being, nutrition, and delirium for future years in the SNF QRP. As the Agency

reviews new measure concepts, CMS will prioritize outcome measures that are evidence-based.

- *Interoperability*
  CMS is seeking input on the quality measure concept of interoperability, focusing on information technology systems' readiness and capabilities in the SNF setting. Specifically, CMS is requesting input and comment on approaches to assessing the secure exchange of electronic health information with, and use of electronic health information from, other health IT without requiring special efforts by the use in the SNF setting. This may include 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 between providers, patients, payers, government agencies and other entities.

- *Well-Being*
  CMS is seeking input on a quality measure concept of well-being for future quality measures for use in the SNF QRP with potential use in the SNF VBP. CMS is requesting input and comment on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, fulfillment, and self-care work, focusing on the relevant aspects of well-being for the SNF setting.

- *Nutrition*
  CMS is seeking input on a quality measure concept of nutrition for future quality measures and for use in the SNF QRP with potential use in the SNF VBP. 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, focusing on the relevant aspects of nutrition for the SNF setting.

- *Delirium*
  CMS is seeking input on a quality measure concept of delirium for future quality measures. 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, focusing on the relevant aspects of delirium for the SNF setting.

- 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. Additionally, 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 FY17 SNF PPS final

rule, CMS 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.

In the process of implementing the public reporting for the quality reporting programs, CMS has identified that the time between when data on measures is collected and submitted to the Agency 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. CMS asserts that 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, CMS states this timeframe provides SNFs with more recent data to use in their quality improvement activities.

Using 2023 data, CMS identified that only 4.2 percent of all MDS assessments were submitted after the 45-day timeframe while only 2.8 percent of MDS assessments would be impacted by changing the data submission timeframe. On these bases, CMS asserts a belief that 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.

CMS is specifically 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.

- Advancing Digital Quality Measurement in the SNF QRP – Request for Information (RFI)
    - In the proposed rule CMS states the Agency is 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.

      For example, CMS is 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. The CMS objective is to explore how SNFs typically integrate technologies with varying complexity into existing systems and how this affects SNF workflows. In this RFI, CMS seeks 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.

CMS is 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.

Specifically, CMS is seeking feedback on the current state of health IT use, including electronic health records (EHRs), in SNF facilities related to the following questions to inform future CMS digital quality measure (dQM) transition efforts.

- *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?*
- *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?* 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.

- Form, Manner, and Timing of Data Submission Under the SNF QRP
  - CMS is not proposing any new policies regarding the form, manner, and timing of data submitted under the SNF QRP.

- Policies Regarding Public Display of Measure Data for the SNF QRP
  - CMS is not proposing any new policies regarding the public display of measure data.

- Economic Impact of Proposed Changes to SNF QRP

- CMS estimates that the overall economic impact of the SNF QRP Program is a decrease of $2.2 million annually beginning with the FY27 SNF QRP.

For any questions pertaining to the information above, please contact Dan Ciolek.

J. Skilled Nursing Facility (VBP) Value-Based Purchasing Program

For the FY26 program year, VBP payment adjustments will be based on four measures. The baseline period was FY22, and the performance period was FY24.

No new measures were proposed for SNF VBP. Table 13 in the proposed rule and copied below provides a summary of the previously finalized measures and when they take effect.

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

For the switch to the SNF Within-Stay Potentially Preventable Readmissions (WS PPR) measure in FY28, CMS proposes scoring the measure using the same method as the other measures. Allowing each measure to contribute equally to the total VBP score, incentive payment multiplier, and payment adjustment.

More specifically, each measure is awarded up to ten points based on improvement or achievement, whichever is greater. The sum of the measure scores is normalized out of a total of 100 points to create the total VBP score. This normalization process allows for measures with missing data to neither harm nor benefit a SNF. SNFs are then ranked based on the total score, which determines the incentive payment multiplier, or payment adjustment.

The individual measure performance standards for FY28 were proposed. For FY29, the performance standards for the two measures with a two-year measurement window (Discharge to

Community and Readmissions) were proposed. The performance standards for the other measure for FY29 will be in next year's proposed rule (FY27 SNF PPS proposed rule).

As a reminder, the benchmark reflects the average rate of the top ten percent of SNFs. A rate at or better than the benchmark rate earns the maximum of 10 points in achievement scoring. The achievement threshold reflects the 25th percentile of performance for all SNFs. Performance better than this value ensures more than zero points are awarded for achievement scoring. The two tables below summarize the performance standards for SNF VBP program years FY28 and FY29 that were provided in tables 14 and 15 of the proposed rule. The rates have been inverted and displayed in their more typical format for ease of comprehension, when applicable.

Proposed FY28 Performance Standards

Measure (Use in Other CMS Program)	**Achievement Threshold (Inverted Rate)**	**Benchmark (Inverted Rate)**
SNF HAI Requiring Hospitalization (QRP)	0.92219 (7.8%)	0.94693 (5.3%)
Total Nurse Staffing (Five-Star)	3.21488 (N/A)	5.81159 (N/A)
Nursing Staff Turnover (Five-Star)	0.40230 (59.8%)	0.75655 (24.3%)
Falls with Major Injury, Long-Stay (Five-Star)	0.95349 (4.65%)	0.99950 (0.05%)
Long-Stay Hospitalization (Five-Star)	0.99758 (2.42 per 1,000 days)	0.99959 (0.41 per 1,000 days)
Discharge Function Score (QRP & Five-Star)	0.40000 (N/A)	0.78800 (N/A)
Discharge to Community (QRP & Five-Star)*	0.42612 (N/A)	0.67309 (N/A)
Readmissions Within-Stay, Potentially Preventable*	0.86372 (13.6%)	0.92363 (7.6%)

*These thresholds were finalized in the FY25 SNF PPS Final Rule

Proposed FY29 Performance Standards (Additional Measure Standards to be Released Next Year)

Measure (Use in Other CMS Program)	**Achievement Threshold (Inverted Rate)**	**Benchmark (Inverted Rate)**
Discharge to Community (QRP & Five-Star)	0.42612 (N/A)	0.67309 (N/A)
Readmissions Within-Stay, Potentially Preventable	0.86372 (13.6%)	0.92363 (7.6%)

CMS proposes removing the Health Equity Adjustment (HEA) that was finalized in the FY24 rule and set to begin with the FY27 program year. CMS believes removing the HEA will improve providers' understanding of SNF VBP and provide clearer incentives. Also, the impact of removing the HEA is seen as small. In their modeling, the average SNF VBP payment adjustment with the HEA was -0.75% and without it was -0.84%. The lower payment adjustment

with the HEA was possible due to the variable payback percentage that would go above 60%. Without the HEA, CMS proposes to maintain a 60% payback.

Finally, CMS proposes an additional reconsideration process starting with the FY27 program year. This new process would be in addition to the existing phase one and phase two review and correction process. The new process would allow SNFs to seek reconsideration if they are not satisfied with CMS' decision on the initial review and correction submitted for either phase one or phase two. Under this new process, SNFs would have 15 calendar days after receiving CMS' decision on the initial correction request to submit another correction request that details the correction request and the reason for it, including any available evidence.

For any questions pertaining to the information above, please contact Kiran Sreenivas.

K. Request for Information on Streamlining Regulations and Reducing Administrative Burdens in Medicare

Included in the proposed rule is an RFI for streamlining regulations and reducing administrative burden. It is based on January 31, 2025, Executive Order (EO) 14192 "Unleashing Prosperity Through Deregulation." It states that the Administration's policy goal is 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.

To comply with the Order, CMS is seeking public input on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program.

The RFI is now available, and the public should submit all comments in response to this RFI through the provided weblink. The link contains a template with ten questions in four sections. Each question allows for up to 10,000 characters or 1,600 words in a response.

AHCA is carefully reviewing what to include in its' RFI response and encourages members to respond, as well.

For any questions pertaining to the information above, please contact Martin Allen.

Conclusion

Comments on the NPRM are due on **June 29, 2025, by 5 PM EST**, which is 60 days after the Proposed Rule is scheduled to be published in the Federal Register on April 30, 2025. Please contact Martin Allen with any questions pertaining to the information in this summary.

AHCA will support its members as they submit comments on the FY26 NPRM and will submit its own comment letter by the June deadline.

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