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Proposed Rule for Nursing Homes: Key Updates for FY 2026

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I. Introduction

The Centers for Medicare & Medicaid Services (CMS) issued the proposed rule on April 11, 2025, for the skilled nursing facility (SNF) prospective payment system (PPS) fiscal year (FY) 2026 update (the proposed rule). Highlights of the proposed rule include:

- A proposed increase to SNF PPS rates by 2.8 percent;
- Updates to Patient-Driven Payment Model (PDPM) ICD-10 code mappings;
- Updates to the SNF Value-Based Purchasing (VBP) Program;
- Updates to the SNF Quality Reporting Program (QRP); and
- A request for information (RFI) for streamlining regulations and reducing administrative burdens.

The proposed changes and their potential impact are detailed more fully below.

II. FY 2026 Proposed Updates to the SNF Payment Rates

For FY 2026, CMS proposes updating SNF PPS rates by 2.8 percent, beginning October 1, 2025. This is based on the proposed SNF market basket increase of 3.0 percent, plus a 0.6 percent market basket forecast error adjustment, and a negative 0.8 percent productivity adjustment. Note that these impact figures do not incorporate the SNF VBP reductions for certain SNFs subject to the net reduction in payments under the SNF VBP. Those adjustments are estimated to total $196.5 million in FY 2025.

CMS indicates that these changes will increase Medicare SNF payments by approximately $997 million in FY 2026.

III. Proposed Changes in PDPM ICD-10 Code Mappings

In FY 2020, CMS implemented the PDPM to improve payment accuracy and appropriateness by focusing on the needs of the whole patient, rather than on the volume of services provided. The PDPM utilizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes in multiple ways. For example, the PDPM uses a patient'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 deliver 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. They are then added, removed, or reassigned 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 October 1, 2024. These 34 codes fall under the following diagnostic categories:

- Type 1 Diabetes Mellitus;
- Hypoglycemia;
- Obesity;

- Anorexia Nervosa, Restricting Type;
- Anorexia Nervosa, Binge Eating/Purging Type;
- Bulimia Nervosa;
- Binge Eating Disorder;
- Pica and Rumination Disorder; and
- Serotonin Syndrome.

For the first eight of the nine categories listed above, CMS is proposing to change the mapping of these codes from "Medical Management" to the clinical category of "Return to Provider." CMS reasons that these diagnoses are not considered specific enough diagnosis for a Part A covered stay clinical category assignment. The "Serotonin Syndrome" diagnosis is proposed to be revised from the "Acute Neurologic" clinical category to the "Medical Management" clinical category.

IV. Proposed Updates to the SNF VBP

For the SNF VBP Program, CMS is proposing a series of operational and administrative updates as part of the rule. Operationally, this would include statutorily required scoring policy updates to the SNF VBP Program. Proposed administrative updates include the creation of a reconsideration policy and the removal of the program's Health Equity Adjustment. The SNF VBP is intended to reward facilities through incentive payments for improvements in quality of care to Medicare beneficiaries. The VBP Program is focused on rewarding SNFs based on value and outcomes rather than volume.

The SNF VBP Program is a pay-for-performance program. As required by statute, CMS withholds 2 percent of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the SNF VBP Program. This 2 percent is referred to as the "withhold." CMS is then required to redistribute between 50 percent and 70 percent of this withhold to SNFs as incentive payments, depending on their performance in the program. CMS applies incentive payments prospectively to all Medicare FFS Part A claims paid under the SNF PPS for the applicable program year (beginning October 1).

CMS is proposing to apply the previously finalized scoring methodology of the program to the SNF Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure beginning with the FY 2028 program year. This would align the scoring methodology applied to the SN FWS PPR measure with the methodology applied to all other measures in the VBP Program.

Second, CMS is providing estimated performance standards for the FY 2028 and FY 2029 program years to comply with the program's statutory notice deadline. These performance standards will apply to the SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI) measure, the Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) measure, the Total Nursing Staff Turnover (Nursing Staff Turnover) measure, the Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury (Long-Stay)) measure, the Number of Hospitalizations per 1,000 Long Stay Resident Days (Long Stay Hospitalization) measure, and the Discharge Function Score for SNFs (DC Function) measure.

Third, CMS is proposing to adopt a reconsideration process that would allow SNFs to appeal CMS's initial decisions for Review and Correction (R&C) requests prior to any affected data being made publicly available. Notably, SNFs would only be able to request reconsideration if they first submit a valid R&C request as set forth in 42 C.F.R. § 413.338(f)(2) or (3). This means that the failure to submit a review and correction request would result in a complete bar to submitting a request for reconsideration. Under this proposed process, SNFs would have 15 calendar days from the date CMS issues a decision on an R&C request to submit a reconsideration request via email.

Finally, CMS is proposing to remove the SNF VBP Program's Health Equity Adjustment beginning in FY 2027. CMS believes that this action would simplify the SNF VBP scoring methodology, provide clearer incentives for SNFs seeking to improve their quality of care for all residents, and have a small overall impact on incentive payment adjustments. If adopted, this change would remove the variable payback percentage beginning in FY 2027 and maintain the 60 percent payback percentage adopted in FY 2023.

V. Proposed Updates to the SNF QRP

For the SNF QRP, CMS is proposing to remove four standardized patient assessment data elements beginning October 1, 2025, and to amend the reconsideration request policy and process. CMS is also seeking feedback on three Requests for Information (RFIs). 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.

CMS's first proposed change to the SNF QRP is to remove four standardized patient assessment data elements categorized under SDOH. The proposed data elements to be removed include "… one item for Living Situation, two items for Food," and one item for Utilities." The removal of these four data elements is expected to reduce both the burden and cost for SNFs to comply with the requirements of the FY 2027 SNF QRP. CMS estimates that the proposed change will result in an annual decrease of 2.08 hours in burden per SNF at admission and a decrease of $2.2 million annually.

CMS is also 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 due to "extraordinary circumstances" – rather than "extenuating circumstances" – and to update the bases on which CMS may grant a reconsideration request. CMS proposes that SNFs affected by an extraordinary circumstance beyond their control (e.g., a natural or man-made disaster) would meet the "extraordinary circumstances" standard. A reconsideration request would be granted if there is a finding that the noncompliance was erroneous.

In support of its request, the SNF would have to submit (1) all evidence supporting compliance with the QRP reporting requirements for the applicable year, (2) documentation that the SNF has been granted an exception or extension, or (3) evidence that the SNF has experienced extenuating circumstances but failed to file a timely request for exception. CMS proposes to modify its reconsideration policy such that it will grant a timely request for reconsideration and reverse a previous finding of noncompliance if CMS determines that the SNF was in full compliance with the SNF QRP requirements for the applicable program year.

CMS also seeks input on several RFIs related to the SNF QRP. The RFIs are specifically related to:

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, reducing the timeframe from 4.5 months to 45 days to 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.

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

On January 31, 2025, President Trump issued Executive Order (EO) 14192, *Unleashing Prosperity Through Deregulation*, which states the Administration's policy to significantly reduce the private expenditures required to comply with federal regulations in order to secure America's economic prosperity and national security, as

well as the highest possible quality of life for each citizen. To comply with the executive order, CMS is including in the proposed rule an RFI seeking public input on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program.

Specifically, CMS invites responses on the following topics:

Streamline Regulatory Requirements

- Are there existing regulatory requirements (including those issued through regulations, 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 or quality/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.

Identification of Duplicative Requirements

- Which specific Medicare requirements or processes do you consider duplicative – either within the program itself or with other health care 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

- CMS welcomes any other suggestions or recommendations for deregulating or reducing the administrative burden on health care providers and suppliers that participate in the Medicare program.

The RFI is available at https://www.cms.gov/medicare-regulatory-relief-rfi, and the public should submit all comments in response to this RFI through the provided weblink.

VII. Deadline to Submit Comments

Comments to the Proposed rule are due on June 29, 2025, by 5 p.m. ET, which is 60 days after the Proposed rule is published in the *Federal Register* on April 30, 2025. Comments may be submitted online here.

VIII. Closing

For additional guidance on the proposed changes to the SNF PPS for FY 2026, please contact Alissa D. Fleming, Mary Grace Griffin, Anna Grace Cole, Samuel Cottle, or any member of the Baker Donelson Health Law team.