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INSIGHTS

FY 2026 Skilled Nursing Facility Prospective Payment System Final Rule

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On July 31, 2025, the Centers for Medicare and Medicaid Services (CMS) released the Fiscal Year 2026 Skilled Nursing Facility Prospective Payment System (SNF PPS) Final Rule. A fact sheet from CMS can be found here. The final rule takes effect on October 1, 2025.

UPDATES TO SNF PAYMENT RATES

As part of the rule, CMS will update SNF rates by 3.2%. This update is based on a final SNF market basket of 3.3%, increased by a 0.6% market basket forecast error adjustment, and reduced by a 0.7% productivity adjustment. The rule is projected to increase SNF payments by $1.16 billion compared to payments in FY25.

A forecasting error occurs when the projected SNF market basket increase differs from the actual increase, with CMS applying an adjustment if the difference exceeds 0.5%. For FY24, the SNF market basket was projected at 3.0% but increased by 3.6%, triggering a 0.6% forecast error adjustment. CMS attributes this error to underestimating the impact of higher-than-expected labor cost growth, particularly in wages and benefits for SNF staff, which drove the actual market basket increase above projections.

The FY26 final rule's net market basket update of 3.2% is 0.4% higher than the 2.8% update in the proposed rule. Specifically, the market basket update rose from 3.0% to 3.3% (due to updated forecasts using more recent cost/claims data through the first quarter of 2025 and reflecting ongoing price pressures), while the productivity adjustment decreased from 0.8% to 0.7% based on revised projections of lower economic growth.

SNF QUALITY REPORTING PROGRAM (QRP)

CMS finalized amendments to the SNF QRP reconsideration policy for FY26, allowing SNFs to request extensions for filing reconsideration requests due to extraordinary circumstances. Requests must be submitted via email within 30 days of noncompliance notification, including the SNF's CCN, business details, contact information, reason for delay, and supporting evidence like photos or media reports. For this change, CMS estimates an incremental administrative burden of 51 hours annually across 202 requests at $2,391.90.

For FY27, CMS finalized the removal of four SDOH standardized patient assessment data elements from the Minimum Data Set (MDS), effective for residents admitted on or after October 1, 2025. The removed items consist of one living situation element (R0310), two food elements (R0320A and R0320B), and one utilities element (R0330). This change reduces the SNF annual reporting burden by 31,791.20 hours and

$2,228,563.12 in costs across 15,253 SNFs, based on a $70.10 hourly composite wage rate for RNs and LPNs.

CMS received varied feedback on future QRP enhancements through three RFIs, including measure concepts for delirium, interoperability, nutrition, and well-being. On a potential delirium measure, supporters noted its value for care, but opponents raised concerns over underreporting, feasibility, and added burden for rural SNFs. For shortening data submission deadlines to 45 days post-quarter, some commenters worried about error rates and advocated for 60 days or phased implementation with technical support. Regarding digital quality measurement via FHIR, stakeholders urged a minimum 12-month transition, voluntary pilots, grants for IT adoption, and safeguards for facilities with limited connectivity. Input generally stressed stakeholder engagement to minimize disparities and administrative load.

SNF VALUE-BASED PURCHASING (VBP) PROGRAM

CMS finalized the scoring methodology for the SNF Within-Stay Potentially Preventable Readmission (WS PPR) measure beginning FY28, replacing the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) and using a hierarchical logistic regression model for risk adjustment. The measure assesses readmissions during SNF stays with a 2-year data period to enhance reportability for low-volume SNFs. Codified at §§ 413.338(e)(1) and (e)(3), it aims to improve performance evaluation accuracy. Commenters supported adoption but raised concerns for low-volume rural SNFs, citing their historically better performance. Suggestions to avoid score inversion for clarity and add bonuses for Tribal facilities were not adopted. This adjustment encourages SNFs to focus on preventing readmissions mid-stay, which could lower overall healthcare expenditures and enhance care continuity.

CMS finalized performance standards for FY28 measures, including SNF HAI (achievement threshold 0.92183, benchmark 0.94491), Total Nurse Staffing Hours (3.29119, 5.87448), Total Nursing Staff Turnover, Falls with Major Injury (Long-Stay), Hospitalizations per 1,000 Long-Stay Resident Days, and DC Function, with minor differences from proposed values. For FY29, standards cover DTC PAC SNF (0.43478, 0.68049) and SNF WS PPR (0.86219, 0.92400). Standards follow the FY17 methodology, with other FY29 measure estimates slated for the FY27 proposed rule. No baseline or performance periods were specified. No specific feedback was provided on these standards. Establishing these thresholds helps facilities prioritize specific metrics to boost their VBP scores and secure better payment adjustments.

CMS finalized the elimination of the Health Equity Adjustment (HEA) bonus points from SNF VBP scoring. Adopted in FY24, the HEA awarded extra points to SNFs serving at least 20% dual-eligible residents while excelling in quality measures like preventing readmissions or reducing falls. It was created to address health disparities, encouraging SNFs to prioritize quality for low-income patients who often face worse outcomes. As part of the HEA, the VBP payback percentage (the portion of the 2% withhold returned as incentives based on performance scores) was adjusted. By raising this payback from 60% to ~66%, the

HEA would have redistributed an additional $50–60 million annually in bonuses without cutting other SNF payments. This would have supported facilities in underserved areas without penalizing others in the program. CMS had previously projected ~15% of SNFs (~2,250 facilities) would have qualified for the enhanced HEA bonus payments.

ICD-10 MAPPING

The ICD-10 mapping in the SNF PPS refers to the system used under the Patient-Driven Payment Model (PDPM) to assign primary diagnoses from Medicare Part A claims to clinical categories for the physical therapy, occupational therapy, speech-language pathology, and non-therapy ancillary components, determining case-mix adjustments and payment rates, with mappings updated annually to reflect new codes and clinical accuracy.

In the FY26 final rule, CMS finalized technical revisions to these PDPM ICD-10 code mappings effective October 1, 2025, through September 30, 2026, specifically changing assignments for 34 new ICD-10 codes effective October 1, 2024: 33 codes (covering conditions like Type 1 diabetes mellitus, hypoglycemia, obesity, anorexia nervosa, bulimia nervosa, binge eating disorder, pica, and rumination disorder) were reassigned to the "Return to Provider" category to prevent their use as primary diagnoses for SNF stays, while one code (G90.81 for serotonin syndrome) was shifted from "Acute Neurologic" to "Medical Management."

According to CMS, these shifts ensure mappings align with current clinical guidelines and coding practices, reducing inappropriate categorizations that could affect reimbursement. No updates were made to Hierarchical Condition Category versions for the SNF Value-Based Purchasing Program or the Within-Stay Potentially Preventable Readmission measure.

REQUESTS FOR INFORMATION (RFIS)

As part of the final rule, CMS does not issue any new requests for information (RFIs). However, it references a standalone RFI on streamlining regulations and reducing administrative burdens, issued separately on January 31, 2025, in response to Executive Order (EO) 14192. To that end, the final rule encourages interested stakeholders to submit feedback on that matter by September 15, 2025.

We trust you found this summary useful. Please reach out to us with any questions.