# Beyond the SNF Final Rule: Reimbursement & Industry Updates
## **Senior Living & Long-Term Care**

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# Your Presenters

## Beyond the SNF Final Rule: Reimbursement & Industry Updates

**Juli Pascoe, CPA**

Partner

**Andy Page, CPA**

Partner

**Deborah Lake, RN, RAC-CT, RAC-CTA**

Senior Managing Consultant

# Agenda

1. FY 2027 Final Rule Update

2. State Medicaid Regulatory Environment

3. Clinical Best Practices & Risk Based Survey

# The Headline Numbers
# FY 2027 SNF PPS at a Glance

CMS issued the FY 2027 SNF PPS Final Rule on July 29, 2026, updating rates effective October 1, 2026.

## Payment increase

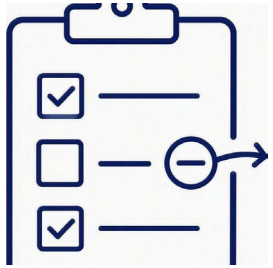
**2.4%**
Net FY 2027 update to SNF PPS rates

**3.3%**
Increase in the market basket

**0.9%**
Productivity adjustment applied to the market basket

**$882.7**
Estimated FY 2027 SNF increase

# SNF Quality Reporting Program
# Measure Removal and Updated Reporting Requirements



## Measure removal, beginning FY 2028

COVID-19 Vaccination Coverage Among Healthcare Personnel

COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

## Effective FY 2029

The data submission window compresses from 4.5 months to roughly 45 days.

All-payer MDS submission begins for residents admitted or readmitted for covered skilled care

# SNF Value-Based Purchasing
# Important Updates

## Payment impact

The existing 2% withhold with a 60% payback structure remains in place.

CMS estimates that FY 2027 VBP will reduce aggregate SNF payments by approximately $203.6 million

## Performance standards

CMS finalized performance standards for the FY 2029 and FY 2030 program years.

Providers should incorporate the standards into multiyear financial planning before the applicable program year

## Review and correction

CMS revised the snapshot date for two measures calculated from MDS assessment data.

The revision aligns VBP with the new, shorter QRP submission deadlines.

The window to review and correct submitted data narrows accordingly.

# Medicare PDPM
# What Remains and What is Next

Treat the PDPM request for comment as a signal, not a non-event. Facilities may wish to monitor case-mix distributions that differ significantly from peer benchmarks as CMS considers potential future rulemaking.

## Held steady for FY 2027

CMS finalized no substantive changes to the PDPM ICD-10 code mappings.

The SNF wage index continues to be based on the IPPS hospital wage index.

Case-mix classification and consolidated billing policy carry forward unchanged.

## Open for future rulemaking

CMS sought comment on potential changes to the Patient Driven Payment Model.

Comments specifically addressed how to respond to observed case-mix upcoding.

No payment model changes were finalized; CMS said it will consider the comments in potential future rulemaking.

# Recommended Next Steps
# Where to Focus

## Revenue Impact

Apply the 2.4% update to your FY 2027 case-mix and volume assumptions.

Model and review the VBP adjustment separately rather than netting it into the rate.

Evaluate your wage index area and check for reclassification effects.

Review that all elements of your Medicare rates are updated in your system.

## Rebuild the reporting calendar

Rework MDS and NHSN workflows against a 45-day close rather than 4.5 months.

Move review-and-correction activity upstream, closer to the point of assessment.

## Prepare now

Review the staffing and system changes needed to assess every covered skilled-care admission, regardless of payer.

Consider benchmarking your PDPM case-mix distribution ahead of future rulemaking

# The State Medicaid Regulatory Environment

Beyond the federal SNF final rule, state-level developments may create significant near-term financial considerations for facilities. Medicaid rate setting, provider tax financing, managed care arrangements, audit activity, and workforce mandates continue to evolve

# State Budget Pressure
# Where Rates Fall Behind Cost

Medicaid nursing facility rates remain highly dependent on each state's fiscal condition, legislative appropriations, and rate-setting methodology. Even where states use cost-based or acuity-adjusted systems, final rates can be constrained by budget neutrality, ceilings, trend factors, occupancy standards, or legislative funding limits.

## Rate-setting risks

Across-the-board Medicaid rate reductions when state appropriations fall short.

Delayed inflation recognition, especially for wages, agency staffing, utilities, food, insurance and other non-labor costs.

Prospective rates based on older cost reports, creating a gap between inflated historical costs and actual cost increases.

## Compounding constraints

Budget neutrality adjustments that reduce the value of acuity-based or quality-based rate updates.

State general fund limitations, driven by broader Medicaid spending pressures and further compounded by federal funding changes.

# Managed Care Exposure
# Directed Payments and Contracts

## State directed payment risk

Existing state directed payments may be grandfathered only temporarily or subject to future limits.

States may lose flexibility to use managed care rate arrangements to support nursing facility payments.

CMS approval delays or documentation requirements may interrupt cash flow.

Payment terms may be limited to approved amounts, requiring amendments when payment levels or methodologies change.

Managed care rate certifications may become more complex and more vulnerable to federal challenge.

## Contracting and payment timing risk

Delays in MCO payment of state-directed or pass-through amounts.

Inconsistent authorization standards across plans.

Claims denials related to level of care, eligibility segments, hospice election, or patient liability.

State-directed payments embedded in capitation rates may not translate cleanly into actual payments.

MCO encounter data errors may affect future rate setting.

# Provider Tax Financing
# OBBBA Limits on State Funding

The One Big Beautiful Bill Act (OBBBA) restricts states' use of provider taxes. Nursing facilities were carved out of most changes, but limits remain on expanding nursing facility taxes and raising existing ones. Reduced capacity for hospitals and other providers could indirectly affect Medicaid funding available for SNFs.

## Limits on assessment capacity

Caps or limits on provider tax growth may prevent states from expanding assessment-funded Medicaid payments.

Freeze provisions can lock states into existing assessment structures and limit flexibility.

## Federal scrutiny and substitution risk

Federal scrutiny of hold-harmless arrangements could create risk for assessment programs viewed as not sufficiently broad-based, uniform, or redistributive.

States forced to replace lost assessment capacity with general fund dollars may find doing so politically or fiscally difficult.

# Occupancy and Case-Mix Risk
# Census and Coding Pressure

## Occupancy standards and underutilized beds

Some states build occupancy standards, minimum occupancy assumptions, or bed-day normalization into rate setting, reducing reimbursement when census falls even though fixed costs remain.

Required occupancy assumptions may penalize facilities with census disruption.

Facilities in rural or oversupplied markets may be disproportionately affected.

Private room conversions may not be fully recognized as the gap between licensed and operational beds widens.

State efforts to rebalance LTSS toward HCBS may reduce nursing facility utilization and weaken facility economics.

## Case-mix and acuity payment

Case-mix adjusted systems are sensitive to assessment accuracy, MDS coding, resident mix, and state-specific normalization factors.

Transition from RUG-based systems to PDPM models.

State normalization or budget neutrality adjustments may reduce acuity gains.

State case-mix audits may not fully align with the federal Resident Assessment Instrument (RAI) Manual, creating confusion and disruption for providers.

Audit findings may result in retroactive rate adjustments.

# Cost Reports and Audits
# Rising State Scrutiny

Many Medicaid systems depend on annual cost reports, periodic rebasing, peer group ceilings, allowable cost rules, related-party rules, compensation limits, property cost rules, and audit adjustments. Providers frequently underestimate the impact of audit activity. Providers may underestimate the potential effect of audit activity

## Cost report scrutiny and rebase risk

More aggressive state audits, with providers bearing both the audit burden and the reimbursement impact as agencies look for savings.

Disallowance of related-party, home office, management fee, lease, interest, or owner compensation costs that providers may dispute

Timing between the cost report year and rate setting, especially problematic in periods of increased inflation.

Rate ceilings that prevent full recognition of allowable costs.

## Audit and program integrity risk

States are investing heavily in Medicaid integrity units and in cost report, MDS, case-mix, provider assessment, and supplemental payment audits.

Retroactive recoupments and rate adjustments.

Increased administrative burden and documentation challenges.

Appeal costs.

# Shifting Demand and Coverage
# Who Receives Care, and Who Pays for It

## HCBS rebalancing and institutional demand

States continue to rebalance LTSS toward home- and community-based services, indirectly affecting nursing facility reimbursement.

Potential impact on long-stay Medicaid census.

Shorter lengths of stay and greater turnover may increase admission and discharge costs and resource burden.

States may prioritize HCBS rate increases over nursing facility rate increases.

## Eligibility, enrollment, and coverage loss

Coverage changes may increase uncompensated care exposure before Medicaid eligibility is established.

Eligibility redetermination delays may increase Medicaid-pending days.

States may respond to federal funding reductions by limiting optional benefits, tightening eligibility, or reducing Medicaid rates.

Medicaid administrative burden may increase for residents, families, facilities, and state agencies.

# Quality Pay and Workforce

# Cost Pressure: Rates May Not Cover Costs

States increasingly tie portions of nursing facility Medicaid reimbursement to quality metrics, value-based purchasing, staffing measures, resident experience, avoidable hospitalizations, and survey performance. Workforce rules also affect whether rates remain adequate.

## Quality-based payment and withhold risk

Quality incentives may become quality withholds.

Facilities with survey deficiencies may lose access to quality add-ons even when specific metrics are being met.

Measures may not fully adjust for resident acuity, behavioral health complexity, payer mix, or workforce availability.

## Workforce mandates and unfunded cost

State Medicaid rates may not fully fund mandated staffing levels.

Increased competition from hospitals, assisted living, home care, and agency staffing firms.

Quality metrics may penalize facilities for staffing shortages that are market-driven.

Higher staffing costs may not be recognized until a future cost report or rebasing cycle.

# Supplemental Payments Facilities May Rely On When Base Rates Fall Short

## What facilities now rely on

Upper Payment Limit (UPL) programs

Quality incentive programs

Directed payments

Nursing facility enhancement payments

Provider assessment-funded add-ons

Workforce incentive payments

State appropriations

## Dependency risks

Supplemental payments become a larger percentage of total Medicaid revenue.

Annual legislative appropriations increase uncertainty.

Payments may be subject to CMS approval.

States may reallocate funds among provider types.

Supplemental payments often lack inflation updates.

## Rural and safety-net risk

High Medicaid payer mix magnifies rate inadequacy.

Low occupancy reduces economies of scale.

Hospital discharge bottlenecks may increase pressure to accept high-acuity residents without adequate payment.

Facility closures may create access issues, especially in rural counties.

Targeted state add-ons may be vulnerable to federal financing limits or state budget cuts.

# Regulatory Watch List
# What to Track From Here

## Federal

OBBBA implementation guidance

CMS state directed payment rulemaking

Provider tax regulations

Medicaid financing reform proposals

Updates to PDPM payment model

## State

Rebase schedules

Provider assessment changes

HCBS expansion initiatives

Staffing mandates

## Operational

Occupancy trends

Medicaid pending days

Agency labor utilization

Quality measure performance

Case-mix audit activity

# Clinical Best Practices & Risk-Based Surveys

# Increased Scrutiny from Payers
# **Mastering Medical Review**

## Considerations for Medical Reviews Across Payers

### Build a Strong Documentation Foundation

- Educate the interdisciplinary team (IDT) and licensed nursing staff on documentation requirements that support payment and reimbursement.
- Provide ongoing training on accurate Section GG documentation and functional scoring.
- Review supporting documentation for diagnoses, services, and payment drivers during routine Medicare meetings.
- Promote consistent documentation among IDT members.

### Establish Effective Review Processes

- Implement a triple check process to verify documentation support prior to claim submission.
- Clearly define IDT responsibilities for gathering, organizing, reviewing, and submitting medical review records.
- Confirm how your facility receives medical review correspondence (mail, email, DDE, or other portals) and monitor regularly.





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# Increased Scrutiny from Payers
# **Mastering Medical Review**

## Strategies for Success with Medical Review for all Payers

### Manage Medical Reviews Proactively

- Develop a standardized process for tracking medical review requests, submissions, and outcomes.
- Maintain organized records and supporting documentation to facilitate timely responses.
- Monitor the status of all claims under review and follow up as needed.

### Evaluate Appeal Options

- Establish criteria for determining when a claim should be appealed.
- Assign accountability for appeal preparation, supporting documentation, and appeal letter development.
- Create a structured appeal workflow to ensure timely and consistent responses.





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# CMS Risk-Based Survey Implementation

**September 8, 2026**
Nationwide RBS launch date

**~12%**
of nursing homes approximately expected to qualify

**5-Star Overall &**
**3-Star or Higher in Staffing**
rating required for eligibility

## What RBS Is

A streamlined alternative to the traditional survey that uses fewer surveyor resources while maintaining oversight of resident health and safety.

Frees agencies to focus on complaints and higher-risk facilities.

## Who Qualifies

- 5-Star Overall Rating
- Adequate staffing levels
- No recent actual harm, immediate jeopardy, or substandard quality of care
- Successful PBJ and MDS audits
- See full list included in CMS Memo

## How Eligibility Is Lost

- Serious complaint allegations
- New enforcement issues
- Staffing waivers
- Ownership changes

Status can change any time before the survey.

## Public Visibility

CMS will publish quarterly lists of qualifying facilities.

A High Performing Facility icon will appear on Nursing Home Care Compare.

### What providers should do

Potential barriers to qualification include the 5-Star Overall Rating and staffing measures. Monitor survey history, staffing ratings, PBJ accuracy, MDS compliance, and complaint activity to keep eligibility and avoid reverting to the traditional survey process.

# Medicare PDPM Best Practices
# **Documentation Matters**

## Building the Foundation for PDPM Accuracy

### Care Planning and Meeting Cadence

- Admission “huddle” meetings for Medicare residents.
- Maintain appropriate care planning and interventions, updating them as indicated.
- Hold daily stand-up and weekly Medicare meetings to keep the team aligned.

### Monitoring and Education

- Use software reports to monitor specific areas – HIPPS codes, diagnosis information, and specific MDS data elements.
- Educate licensed nursing personnel on appropriate assessment, documentation, and follow-up.





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# Medicare PDPM Best Practices
# **Sections C, D, and J**

## Staff Assessment Documentation Requirements

### What Your Documentation Must Show

- The date(s) and the staff member(s) interviewed across all shifts.
- The dates of staff observations with detailed description of resident symptoms, impairments, and frequencies.
- The frequency reports for each applicable item in these sections.

### Where Facilities Fall Short

- Interviewing one individual and using that as the staff assessment is not adequate to support coding the staff assessment data elements.

# Medicare PDPM Best Practices
# **Section GG**

## PT/OT and Nursing Function Scores

### Verify Your Software Definitions

- Make certain your software contains the correct definitions of each task and quality of performance for: eating, oral hygiene, toileting hygiene, sit to lying, lying to sitting on side of bed, chair/bed to chair transfer, toilet transfer, walk 50 feet with two turns, and walk 150 feet.
- Correct definitions must also be in software for the 6-point scale for resident performance: independent, set up or clean up assistance, supervision or touching assistance, partial/moderate assistance, substantial/maximal assistance, and dependent.

### Collect Within the Right Window

- Make sure data is collected for the appropriate time frame, with IDT collaboration used in the decision-making process for coding Section GG.
- Admission / 5-day PPS assessment: Days 1–3.
- Quarterly, Annual, SCSA, and IPA: ARD and 2 days prior.

# Medicare PDPM Best Practices
# **Supporting Active Diagnoses**

## Documentation Best Practices

### What Makes a Diagnosis Active

- Physician or practitioner documentation in the 60-day look-back period from the ARD of the MDS, along with monitoring or treatment in the 7-day look-back from the ARD.
- Monitoring or treatment: medications, patient-specific interventions, restorative nursing, etc.

### Document the “Why”

- Simply having an order for the head of the bed to be elevated is not adequate. The intervention must include why the head of the bed needs to be elevated.
- “Head of bed elevated at 30 degrees at all times per patient request due to shortness of breath while lying flat as a result of COPD.”

# Medicare PDPM Best Practices
# **Nutrition and Skin**

## Documentation a Reviewer Can Verify

### Tube Feeding and IV Intake

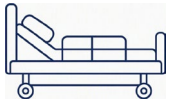
- Proportion of total calories received through parenteral or tube feeding: documentation must allow any medical reviewer to calculate the proportion for the 7-day look-back period. Meal or pleasure feeding percentages are not adequate.
- Average fluid intake per day by IV or tube feeding: documentation must allow any reviewer to calculate the average daily intake for the 7-day look-back period.
- May require calorie count for residents receiving po intake and tube feeding at the same time.
- Good documentation of need for IV fluids for nutrition and/or hydration.

### Skin Conditions

- Accurate identification of etiology of skin conditions: open lesions, diabetic foot ulcers, arterial/venous ulcers, etc.
- At least weekly documentation of all skin conditions, including location, description, measurements, treatments, other interventions, and progress.
- Maintain consistency with the individual who is assessing.

# Medicare PDPM Best Practices
# **Isolation, Oxygen and Sign-Off**

## Final Documentation Checkpoints



### Isolation

- Active infection – highly transmissible or pathogens acquired by physical contact, airborne, or droplet transmission.
- Resident in a room alone, with all services brought to their room.
- Documentation of the need for transmission-based precautions and strict isolation alone in a separate room.
- Other support: positive lab test, positive for s/sx.
- Does not apply to UTIs, wound infections, or encapsulated pneumonia.

### Oxygen and Signature Dates

- Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc., delivered to relieve hypoxia during the observation period.
- If PRN oxygen, there must be documentation in the observation period of the precipitating event.
- If a staff member cannot sign Z0400 on the day a section or portion was completed, the staff member should use the date the item was originally completed when signing.





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# Contact

## Forvis Mazars

**Juli Pascoe, CPA**
Partner
P: 417.522.0481
juli.pascoe@us.forvismazars.com

**Andy Page, CPA**
Partner
P: 919.526.1836
andy.page@us.forvismazars.com

**Deborah Lake, RN, RAC-CT, RAC-CTA**
Senior Managing Consultant
P: 260.460.4026
deborah.lake@us.forvismazars.com