Forvis Mazars

Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates

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Forvis Mazars

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Agenda

1. CMS FY 2026 SNF Payment Final Rule
2. Cost Report Form Changes
3. Other Hot Topics
    1. Provider Revalidation
    2. Medicaid Acuity Transitions (RUGS to PDPM)
    3. OBBA Changes
    4. Medical Reviews

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FY 2026 SNF Payment Rule

Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates
CMS FY 2026 SNF Payment Rule

Key Provisions of the Final Rule

- **Payment Rate Adjustments** – The final rule outlines a 3.2% net increase in Medicare payments to SNFs for FY2026. This increase is derived from the following:
  - **Market Basket Increase (+3.3%)** – Reflects the estimated changes in the cost of goods and services included in the covered services for the Medicare SNF benefit, *e.g.*, wage-related costs, supplies, ancillary services, etc.
  - **Forecast Error Adjustment (+0.6%)** – Reflects the difference in the latest available fiscal year's forecasted market basket increase and the actual market basket increase for the same period
  - **Productivity Adjustment (-0.7%)** – To help ensure that rate adjustments reflect actual increases in costs versus gains in employee productivity

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TABLE 4: FY 2026 Unadjusted Federal Rate Per Diem - URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$75.73	$70.49	$28.28	$132.00	$99.59	$118.21

TABLE 5: FY 2026 Unadjusted Federal Rate Per Diem - RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$86.33	$79.29	$35.63	$126.12	$95.15	$120.40

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

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

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CMS FY 2026 SNF Payment Rule

PDPM ICD-10 Code Updates

- Each year, CMS reviews the clinical category assignments for new ICD-10 codes and proposes edits to their assigned categories. For FY 2026, CMS made changes for **34 new ICD-10 codes** that became effective **October 1, 2024**

- Codes from the following categories will be re-assigned from Medical Management to Return to Provider for PDPM ICD-10 mapping:
  - *Type 1 Diabetes*
  - *Hypoglycemia*
  - *Obesity*
  - *Anorexia*
  - *Bulimia*
  - *Binge Eating*
  - *Pica & Rumination*

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PDPM ICD-10 Code Updates

- Coding for the following diagnosis will be re-assigned from Acute Neurological to Medical Management for PDPM ICD-10 mapping:
    - *Serotonin Syndrome*

- It is important to understand the category assignments for these ICD-10 codes and the overall impact on case mix index. The accuracy of ICD-10 coding continues to be a critical focus area for providers

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CMS FY 2026 SNF Payment Rule

Quality Reporting Program (SNF QRP)

- The SNF QRP requires SNFs to report quality data on specific measures, including those related to falls, pressure ulcers, and functional assessments. The data is collected and submitted through three separate methods:
  - Minimum Data Set (MDS) 3.0
  - Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)
  - Medicare Fee-for-Service Claims

- Providers who fail to properly submit QRP data are subject to a 2% reduction in their overall Medicare reimbursement

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CMS FY 2026 SNF Payment Rule

Quality Reporting Program (SNF QRP)

- Effective January 1, 2024, facilities must meet compliance thresholds for two measures for Quality Reporting:
  - Annual MDS submission threshold
    - 90% of submitted MDS assessments with 100% of required SNF QRP data elements

- NHSN data submission requirement for Health Care Provider COVID-19 and Influenza Vaccination:
  - NHSN compliance rate is 100%
  - COVID Vaccination
    - Submission of all required data elements for a minimum of one week per month per quarter
  - Influenza Vaccination
    - Summary data must be entered by May 15 of each year

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- **Table 12 from the FY 2026 Rule represents the measures in place for FY 2028 SNF QRP:**

TABLE 12: Quality Measures Currently Adopted for the FY 2028 SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
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
Claims-Based	
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
National Healthcare Safety Network	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

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CMS FY 2026 SNF Payment Rule

Quality Reporting Program (SNF QRP)

- For FY 2026, CMS is finalizing its proposal to remove four standardized patient assessment data elements under the Social Determinant of Health (SDOH) category for the MDS beginning with residents admitted on October 1, 2025. These four items were previously adopted and include:
  - One item for Living Situation
  - Two items for Food
  - One item for Utilities

- In addition, CMS is finalizing their proposal to amend the reconsideration policies for noncompliance with QRP
  - Allow SNFs the ability to request an extension to file a request for reconsideration
  - Updating bases on which CMS can grant a reconsideration
  - Updating of language from Extenuating to Extraordinary circumstances

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CMS FY 2026 SNF Payment Rule

Quality Reporting Program (SNF QRP)

- Feedback is being requested on requests for information (RFIs), specifically on:
  - Future measure concepts for the SNF QRP
  - Potential revisions to the data submission deadlines for assessment data collected for the SNF QRP
    - 4.5 months vs. 45 days
  - Advancing digital quality measurement in SNF

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CMS FY 2026 SNF Payment Rule

SNF Value-Based Purchasing (VBP) Program Changes:

- The VBP program is designed to provide incentive payments to SNFs based on performance within defined quality measures

- The VBP program has served as an example of transitioning Medicare payments toward better quality as opposed to only rewarding volume
  - The final rule for FY 2026 includes modifications to the VBP scoring policies, the introduction of a reconsideration process (beginning with the FY 2027 program year), and the removal of the Health Equity Adjustment, which was implemented in FY 2024

- Replacement of the SNF 30-Day All Cause Readmission Measure (SNFRM) is on pace to be replaced with the SNF Within-Stay Potentially Preventable Readmission Measure (SNF WS PPR) in FY 2028 program year

- The VBP program has evolved from solely a measurement of provider readmission rates to include multiple other quality factors

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- **Table 14 from the FY 2026 Rule represents the VBP program measures included in the calculations:**

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 Majority Injury (Long-Stay)(Falls with Major injury (Long-Stay)) measure		Included	Included	Included
Discharge Function Score for SNFs (DS 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

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Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates
CMS FY 2026 SNF Payment Rule

Administrative Presumption of Coverage:

- Administrative Presumption of Coverage
  - Updated annually in Final Rules
  - Reflect an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers in their initial Medicare assessment (5-day) are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) of that assessment

- For services furnished on or after October 1, 2019, the following are the designated case-mix classifiers:
  - Nursing Component: Extensive Services, Special Care High, Special Care Low and Clinically Complex categories
  - PT and OT Component: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO
  - SLP Component: SC, SE, SF, SH, SI, SJ, SK and SL
  - NTA Component: Uppermost (12+) comorbidity group

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Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates
CMS FY 2026 SNF Payment Rule

Regulatory Streamlining:

- On January 31, 2025, President Donald Trump issued Executive Order (EO) 14192, "Unleashing Prosperity Through Deregulation," which outlines the administration's goal of reducing expenditures required to comply with federal regulations

- CMS is seeking public input on opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other stakeholders participating in the Medicare program

- CMS has made available an RFI on the CMS site

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Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates

CMS Final FY 2026 SNF Payment Rule

Summary

- The key takeaway of the FY 2026 Final Rule surrounds the payment adjustment for FY 2026, calculated at a projected 3.2% increase. The overall economic impact of the final rule is estimated at:
  - **Overall Increase**: Estimated $1.16 billion increase in aggregate payments to SNFs
  - **SNF VBP Program**: Estimated $312 million for FY 2026
- While the payment increase offers some financial relief to SNFs, the emphasis on regulatory efficiency and performance-based incentives also shows CMS' continued commitment to quality care
- For more information, See the full Final Rule here: Federal Register: Public Inspection: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026

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Medicare Cost Report Form Changes

Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates

New CMS 2540-24 Form – Effective Beginning With FYEs 9/30/25

Medicare Cost Report Purpose & Content:

- Report financial and statistical information to the Centers for Medicare and Medicaid Services (CMS) to determine Medicare reimbursement rates and for broader policy decisions

- Provide transparency and accountability by providing detailed information of SNF costs and operations

The changes to the cost report form are intended to allow Medicare to:

1. Obtain more relevant data for rate setting
2. Refine SNF Market Basket modeling
3. Possible development of SNF Wage Index
4. Calculate program margins
5. Make recommendations to legislators

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Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates

New CMS 2540-24 Form – Effective Beginning With FYEs 9/30/25

Key Changes:

- Eliminated non-applicable worksheet series for RHC/FQHC and CMHCs
- Updated the H series and S-4 for SNF based home health to be consistent with freestanding Form CMS1728-20
- Redesignated the SNF based hospice O worksheet series to K series

- Additional questions added to Worksheet S-2:
  1. *Did SNF operate a ventilator unit?*
  2. *Did SNF operate a Medicare approved laboratory with its own CLIA number or CLIA certificate of waiver?*
  3. *Did SNF operate a radiological department that meets the standards required of a hospital furnishing such services or the standards to provide portable x-ray services?*
  4. *Did the SNF operate an institutional based ambulance service?*

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Tackling the Final Rule for SNFs: Reimbursement & Cost Report Updates

New CMS 2540-24 Form – Effective Beginning With FYEs 9/30/25

Key Changes Cont.:

- Worksheet S-3 changes to capture inpatient days and discharges for Medicare Advantage/Medicare HMO and Medicaid HMO
- Worksheet A updates to remove obsolete cost centers and add new cost center descriptions, change cost center numbers. Also added column to separately identify contract labor expenses
- Added capital reconciliation to Worksheet A-7
- Added Worksheet C-6 for revenue reclasses
- Revised Worksheet G-2 to provide revenue data, broken out by provider payment and delivery system to support margin analysis

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New CMS 2540-24 Form – Effective Beginning With FYEs 9/30/25

What Providers Need to Do:

In efforts to meet the new reporting requirements, Providers should assess the way Medicare Advantage and Managed Medicaid payers are reported in their revenue cycle management and general ledger software

Census, admissions, and discharges should also be recorded by new reporting requirements to separate Medicare Managed Care/HMO and Managed Medicaid. Commercial Insurance Policies such as long-term care policies or individual/group health insurance are separate from Medicare Advantage Plans

- Payer set-ups and revenue mapping within the AR system will need to be reviewed and updated as needed
- New general ledger accounts may need to be established as the general ledger trial balance and financial reporting should match the AR system

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Hot Topics

SNF Provider Revalidation Applications Extended Again

Deadline for Submission January 1, 2026

Please Keep in Mind the Following:

While this extension offers some breathing room, the scope of required information **remains unchanged.**

Depending on your facility's ownership and control structure, gathering and submitting the necessary documentation may still be a **time-intensive process.**

Here are some practical steps providers should consider:

- Submit your application sooner rather than later
- Understand what is and is not an "additional disclosable party" (ADP)
- Tell your story clearly
- Reach out to your Forvis Mazars Advisor if you have questions interpreting the requirements or completing the revalidation process

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Medicaid Plans – RUGS to PDPM Transitions Are Happening

What Providers Need to Understand:

- Timing
- What components of PDPM are going to be utilized
- Transition methods vary by state
- Provide appropriate education to the entire IDT team including MDS Coordinators on what criteria drive PDPM component classifications
- Review case mix index performance and shadow rates if available

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Washington Outlook
OBBA Changes

What Senior Living & Skilled Nursing Providers Need to Know

- Provider taxes are frozen at current levels
- Delays the unfunded minimum staffing mandate ratio requirement
- Medicaid eligibility
    - (Sec. 71112) This section specifies that, beginning with the first quarter after December 31, 2026, Medicaid coverage may begin retroactively (1) for individuals in the Medicaid expansion population, one month prior to the application filing date; and (2) for all other individuals, two months prior to the application filing date. Additionally, CHIP coverage may retroactively begin two months prior to the application filing date. (Currently, coverage may begin three months prior to the application filing date.)

    - (Sec. 71107) This section requires state Medicaid programs to redetermine every six months, beginning with the first quarter after December 31, 2026, the eligibility of individuals who are enrolled in Medicaid as part of the Medicaid expansion population under the Patient Protection and Affordable Care Act. (The act allows states to extend Medicaid coverage to all adults under the age of 65 with incomes of up to 138% of the federal poverty level, including able-bodied adults without dependent children.)

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Medical Reviews
Current Trends

Best Practices for Medical Record Review

- **Ensure facility contact information is up to date with MACs, etc.**
  - Ensure communications from MACs, RACs, etc., are identified and addressed in a timely manner

- **Read letters for request of Medical Record Review thoroughly**
  - What information are they requesting and why?
  - What service periods are records being requested for?
  - When are records due to the review entity?

- **Supply documentation to support being paid for the requested time frame and services**
  - Utilize checklists to ensure all supporting information is included
  - Establish a process for gathering, reviewing, submitting, and tracking the data
  - Ensure data is submitted in a timely manner – keep validation that information was received

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