# FROM COMPLIANCE TO CONFIDENCE:

## NAVIGATING 2026 REIMBURSEMENT & REGULATORY CHANGES

**A Functional Pathways White Paper**

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## Introduction

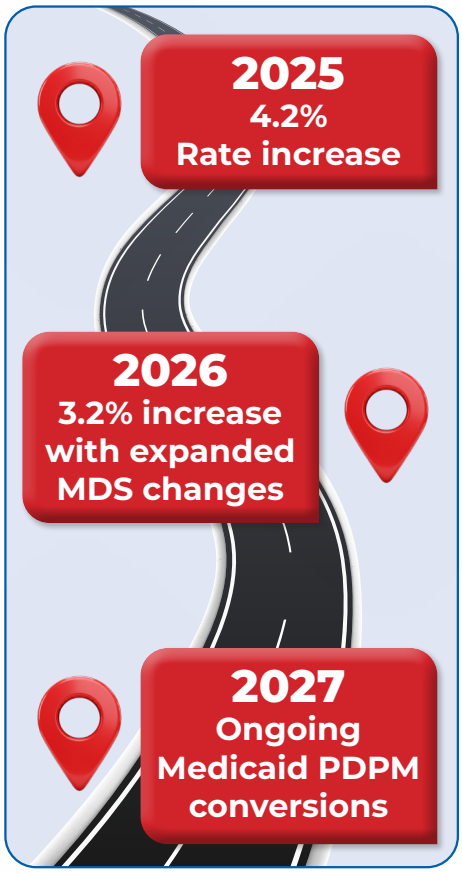
The healthcare landscape continues to evolve, and with each new fiscal year comes increased complexity in reimbursement and regulation. The Fiscal Year 2026 Final Rule introduces significant updates that affect every skilled nursing facility across the country, from payment structures and coding to documentation and data validation.

These changes are not just administrative requirements. They reflect a continued shift toward accuracy, transparency, and resident-centered care. Understanding the new standards is essential for communities that want to maintain compliance, protect revenue, and ensure the highest quality outcomes for residents.

## Background: Changing Financial and Regulatory Landscape

Fiscal Year 2026 introduces another round of updates under CMS's Prospective Payment System and the Patient-Driven Payment Model. The rule includes a 3.2 percent increase in SNF PPS rates, totaling approximately 1.16 billion dollars in additional payments, along with refinements to how rates are adjusted by geography and labor costs.

These changes continue CMS's focus on aligning financial incentives with clinical accuracy, quality performance, and measurable outcomes. For therapy and clinical teams, this requires collaboration across departments to ensure data integrity and consistency in MDS coding, while understanding how reimbursement is directly tied to documentation.




## The Challenge of Change

Regulatory updates arrive each October, bringing in new coding requirements, reporting expectations, and quality measures. These changes can create fatigue and confusion across clinical and financial teams.

**The 2026 updates require providers to:**

- Interpret the latest PDPM mapping and ICD-10 coding guidance
- Adapt to MDS version 1.21.0.1 with revised skip patterns and removals
- Prepare for more rigorous data validation and survey readiness
- Align Medicaid processes with continued PDPM adoption across states

This level of change reinforces the need for structured communication, strong leadership, and interdisciplinary education to keep operations running smoothly.

## Why It Matters

Accurate documentation is the foundation of both compliance and quality care. CMS's expanded use of validation audits and quality measures means that clinical accuracy directly influences financial stability.

When documentation is consistent across therapy, nursing, and administrative teams, it supports reimbursement integrity and strengthens the organization's reputation. Errors or inconsistencies can lead to payment reductions, compliance concerns, and missed opportunities for quality recognition.

## Strategies That Work

**1. Understand and Communicate Payment Updates**

The 3.2 percent payment increase comes with regional wage index adjustments that can vary by location. Facilities should review how these updates impact their daily rates and ensure that billing, therapy, and leadership teams all interpret the information consistently.

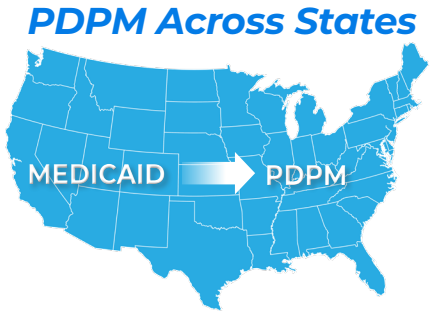
**2. Master the 2026 MDS Structure**

MDS version 1.21.0.1 introduces several changes, including revised gender terminology, new skip patterns, and the removal of therapy and recreational items from Section O. These updates are designed to reduce administrative burden but require adjustments in documentation.

Teams should review coding practices and cross-check documentation to ensure accuracy and consistency across disciplines.

**3. Prepare for Medicaid PDPM Conversion**

Many states are now implementing PDPM-based Medicaid models. This transition requires accurate coding and monitoring to ensure residents continue to maintain their highest practical level of function. Regardless of payer source, therapy and clinical teams must remain focused on identifying both improvement and decline to ensure appropriate interventions are provided.




**4. Stay Ahead of QRP and VBP Adjustments**

CMS has removed several SDOH items from the MDS, such as living situation and utilities, estimating that these changes will save providers more than 31,000 hours of staff time annually.

The Value-Based Purchasing program continues to withhold 2 percent of SNF Part A payments, redistributing 60 percent as incentive payments and retaining 40 percent within the Medicare Trust Fund.

**5. Strengthen Data Validation and Audit Readiness**

New MDS data validation audits began in October 2025. Facilities are selected at random and must submit supporting documentation within 45 days of notification in their iQIES -Provider Preview Reports folder. Identifying a staff member responsible for daily monitoring of these reports is essential to maintaining compliance.


## Beyond Compliance: Building a Culture of Preparedness

Compliance is most effective when it is part of the culture rather than a checklist. A proactive approach ensures that teams are not reacting to changes but anticipating them. Open communication, cross-department collaboration, and consistent education allow organizations to move from compliance to confidence.

When every team member understands their role in documentation accuracy and regulatory readiness, the result is a stronger, more resilient community that can adapt quickly and continue to deliver exceptional care.

## Conclusion

The 2026 Final Rule reinforces CMS's ongoing commitment to accuracy, accountability, and transparency. Senior living and skilled nursing communities that respond proactively will maintain compliance while enhancing the quality of care they deliver.

By embracing education, collaboration, and clear communication, providers can transform these updates into opportunities for improvement and growth, ensuring that compliance remains a pathway to better outcomes.

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