FY 2027 Skilled Nursing Facility Final Rule

Summary of the Most Consequential Changes to the Skilled Nursing Facility Program

CMS-1843-F | Effective October 1, 2026

Source: https://public-inspection.federalregister.gov/2026-15562.pdf

Executive Summary

- Net FY 2027 payment update: CMS finalized a 3.3% market-basket increase, reduced by a 0.9 percentage-point productivity adjustment, producing a 2.4% net SNF PPS update. CMS estimates this will increase aggregate Part A payments by approximately $882.74 million before SNF VBP effects.
- SNF VBP offset: The FY 2027 SNF VBP Program is expected to reduce aggregate SNF payments by approximately $203.60 million through the existing 2% withhold and 60% payback structure.
- Accelerated quality-data deadlines: Beginning with the FY 2029 SNF QRP, MDS and applicable CDC NHSN data must generally be finalized by the 15th day of the second month following each quarter—roughly 45 days, rather than 4.5 months.
- All-payer MDS expansion: Beginning with residents admitted on October 1, 2029, SNFs must submit MDS data for residents admitted or readmitted for covered skilled care regardless of payer. CMS estimates approximately $88.0 million in additional annual burden across SNFs beginning with the FY 2031 SNF QRP.
- COVID-19 measure removal: CMS is removing both the healthcare-personnel and resident COVID-19 vaccination measures from the SNF QRP beginning with FY 2028, with associated public reporting ending after the October 2026 Care Compare refresh.

Reference pages: Final Rule PDF pp. 1-3.

1. FY 2027 SNF PPS Payment Update

CMS finalized a 2.4% net update to SNF PPS rates for FY 2027. The calculation begins with a 3.3% increase in the 2022-based SNF market basket, applies no forecast-error adjustment, and subtracts a 0.9 percentage-point productivity adjustment. CMS estimates the result will increase aggregate Medicare Part A SNF payments by approximately $882.74 million in FY 2027, before the separate financial effects of the SNF VBP Program.

The unadjusted federal per diem components increase for both urban and rural SNFs. For example, the urban nursing component rises from $132.00 to $135.02 and the rural nursing component rises from $126.12 to $129.00. The final rates apply to services furnished from October 1, 2026, through September 30, 2027, and remain subject to PDPM case-mix, wage-index, variable per diem, VBP, and other applicable adjustments.

Financial significance: Although the rule provides a positive nominal update, the 2.4% increase may not fully reflect facility-specific cost growth, and each SNF's actual result will depend materially on its wage index, case mix, utilization, VBP performance, and QRP compliance. A SNF that fails the

SNF QRP requirements remains subject to a 2 percentage-point reduction to its annual payment update.

Reference pages: Final Rule PDF pp. 7-20, 168-171.

2. Wage Index, Labor Share, and Distributional Effects

CMS continues to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index—without the occupational-mix, rural-floor, or outmigration adjustments—as the basis for SNF wage adjustment. The permanent 5% cap on year-over-year wage-index decreases also remains in effect. For FY 2027, CMS finalized a labor-related share of 72.0% and a wage-index budget-neutrality factor of 0.9989.

The aggregate wage-index update is budget neutral, but it redistributes payments among facilities and regions. CMS projects an average total increase of 2.4% for urban SNFs and 2.7% for rural SNFs. Hospital-based urban and rural SNFs are projected to receive average increases of 2.9%, compared with 2.3% for freestanding urban SNFs and 2.7% for freestanding rural SNFs. Regional effects vary significantly—for example, rural Mountain facilities are projected at only a 0.5% increase, while rural New England facilities are projected at 4.6%.

Operational significance: SNFs should not budget solely from the national 2.4% update. Facility-specific wage-index files and the 72.0% labor share should be incorporated into FY 2027 revenue forecasts, particularly for facilities in regions experiencing negative wage-data effects.

Reference pages: Final Rule PDF pp. 26-35, 169-170.

3. No Immediate PDPM Recalibration or Case-Mix-Creep Reduction

CMS did not finalize substantive FY 2027 changes to the PDPM ICD-10 mappings. Only non-substantive updates needed to maintain consistency with current ICD-10 codes will be made through CMS's subregulatory mapping files. Requests to remap several diagnoses were deferred for potential future rulemaking.

CMS also did not adopt a case-mix-creep payment adjustment in this final rule. Instead, the agency summarized comments on its methodology RFI and stated that it will consider proposed adjustments in future rulemaking. This avoids an additional PDPM reduction for FY 2027, but it signals a significant future payment risk—especially for the nursing and non-therapy ancillary components—if CMS later determines that coding changes have increased case-mix indexes without corresponding changes in resident acuity.

CMS likewise retained the hospital-based wage-index methodology for FY 2027 and did not adopt a SNF-specific wage index. The agency continues to evaluate alternative data sources, including Bureau of Labor Statistics data and SNF cost-report information, for possible future years.

Reference pages: Final Rule PDF pp. 47-61.

4. Removal of Two COVID-19 Measures from the SNF QRP

Beginning with the FY 2028 SNF QRP, CMS is removing: (1) the COVID-19 Vaccination Coverage Among Healthcare Personnel measure; and (2) the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure. CMS concluded that the measures no longer align with evolving clinical guidance and that their reporting burden outweighs their continued value.

- Healthcare-personnel measure: SNFs will not be required to report CY 2026 data for the FY 2028 payment determination, and failure to report those data will not trigger an FY 2028 QRP payment penalty. Removal from the SNF QRP does not eliminate other infection-control or reporting duties that may apply under 42 CFR 483.80.
- Resident measure: For residents discharged on or after October 1, 2026, collection and submission are no longer required. MDS item O0350 becomes voluntary on that date and is scheduled for technical removal from the MDS on October 1, 2027.
- Public reporting: Both measures will be displayed for the last time in the October 2026 Care Compare refresh, based on Q4 2025 data. Voluntarily submitted data will not continue to be publicly displayed after the measures are removed.

CMS estimates the combined reporting relief at approximately 12.5 hours and $564.81 per SNF annually, or about $8.4 million across all SNFs each year.

Reference pages: Final Rule PDF pp. 65-78, 135-138, 171-173.

5. SNF QRP Data-Submission and Correction Deadlines Are Shortened

Beginning with the FY 2029 SNF QRP—using CY 2027 data—SNFs must complete MDS submissions and corrections, and applicable CDC NHSN submissions and corrections, no later than the 15th day of the second month after the end of each calendar quarter. This replaces the current MDS timeframe of approximately 4.5 months with a deadline of roughly 45 days. If the 15th falls on a Friday, weekend, or federal holiday, the deadline moves to 11:59 p.m. Eastern Time on the next business day.

Quarter	Data Collection Period	Final Deadline
CY 2027 Q1	January 1-March 31, 2027	May 17, 2027
CY 2027 Q2	April 1-June 30, 2027	August 16, 2027
CY 2027 Q3	July 1-September 30, 2027	November 15, 2027
CY 2027 Q4	October 1-December 31, 2027	February 15, 2028

CMS expects the change to reduce the lag in public reporting by approximately three months. The agency declined requests for a phased implementation or grace period, citing data showing that most SNFs already submit within 45 days. Facilities will therefore need earlier internal validation, vendor review, and correction workflows. Missing the accelerated deadlines can affect QRP compliance and expose the facility to the statutory 2 percentage-point annual-update reduction.

Reference pages: Final Rule PDF pp. 82-91.

6. Major Expansion to All-Payer MDS Reporting

The most consequential long-term administrative change is CMS's requirement that SNFs submit MDS data for residents admitted or readmitted for covered skilled care regardless of payer. The policy begins with residents admitted on October 1, 2029, for the FY 2031 SNF QRP. Starting in CY 2030, a full calendar year of all-payer data will be required for the FY 2032 SNF QRP.

The requirement applies when all four of the following conditions are met:

- The resident is admitted for covered skilled nursing or rehabilitation services that must be performed by or under professional or technical supervision and are ordered by a physician.
- The resident requires the skilled services on a daily basis.
- As a practical matter, the daily skilled services can be furnished only on an inpatient basis in a SNF.
- The services are reasonable and necessary for the resident's illness or injury and reasonable in duration and quantity.

The policy is limited to residents admitted or readmitted for covered skilled services. It generally does not apply merely because a long-stay resident is "skilled in place" without a discharge and readmission. A return from a leave of absence does not trigger a new skilled-care admission assessment, and a short-term resident returning within the three-day interruption window generally continues the prior stay. The rule also notes an exemption where the third-party insurer does not cover the cost of skilled services.

SNFs will use the Nursing Home PPS admission assessment and Nursing Home Part A PPS Discharge assessment—and corresponding swing-bed assessments—for non-Medicare FFS residents. CMS will modify one MDS item and add three new items to identify non-FFS skilled admissions/discharges, the primary payer, and the start and end dates of the covered skilled stay.

Compliance and cost implications: The all-payer data will count toward SNF QRP compliance. Under the existing completeness standard, 90% of submitted MDS assessments must contain 100% of required data. CMS estimates an added annual burden of 67.26 hours and $5,911.51 per SNF, totaling approximately 1.0 million hours and $88.0 million annually across all SNFs. CMS did not finalize a new public-reporting policy for the non-FFS data in this rule, but indicated that future reporting changes may follow.

Reference pages: Final Rule PDF pp. 91-134, 153-166, 171-174.

7. SNF Value-Based Purchasing Program Updates

For FY 2027, the existing VBP financing structure remains highly consequential. CMS will withhold 2% from each participating SNF's adjusted federal per diem rate and redistribute 60% of the withheld amount based on performance. CMS estimates approximately $508.99 million will be withheld, $305.39 million will be redistributed, and the net reduction in aggregate SNF payments will be approximately $203.60 million.

To receive a performance score and value-based incentive payment for FY 2027, a SNF must meet the applicable case minimum for at least four of the eight measures. CMS estimates that 1,508 SNFs will fail the measure-minimum requirement and therefore will not receive a performance score under the modeled FY 2027 program.

CMS finalized the following achievement thresholds and benchmarks for future program years:

Program Year	Measure	Achievement Threshold	Benchmark
FY 2029	SNF HAI	0.92102	0.94355
FY 2029	Long-Stay Hospitalization	0.99762	0.99960
FY 2029	Nursing Staff Turnover	0.44444	0.77731

Program Year	Measure	Achievement Threshold	Benchmark
FY 2029	Total Nurse Staffing	3.33606	5.98992
FY 2029	DC Function	0.42857	0.84522
FY 2029	Falls with Major Injury	0.95522	0.99945
FY 2030	SNF WS PPR	0.85620	0.92121
FY 2030	DTC PAC SNF	0.43459	0.68006

CMS also shortened the VBP "snapshot date" for the DC Function and Falls with Major Injury measures, beginning with FY 2027 data, to the 15th day of the second month after the end of the applicable baseline or performance period. The change aligns VBP with the new QRP MDS deadline. CMS rejected a grace period, making timely correction of underlying MDS data more important because corrections made after the snapshot date will not flow into VBP measure calculations and confidential feedback reports.

Reference pages: Final Rule PDF pp. 138-152, 173-177.

8. Key Implementation Dates and Recommended Priorities

Date	Required Action or Milestone
October 1, 2026	FY 2027 SNF PPS rates take effect; resident COVID-19 vaccination data become voluntary for discharges on or after this date.
October 2026	Last Care Compare refresh displaying the two COVID-19 vaccination measures.
January 1, 2027	CY 2027 data collection begins for the accelerated FY 2029 SNF QRP submission deadlines.
May 17, 2027	First accelerated MDS submission/correction deadline, covering CY 2027 Q1.
October 1, 2027	MDS item O0350 is scheduled for technical removal.
October 1, 2029	All-payer MDS submission begins for residents admitted or readmitted for covered skilled care.
FY 2031 SNF QRP	First payment year in which the all-payer MDS requirement applies.

Priority actions for SNFs include updating FY 2027 revenue models with the facility-specific wage index and VBP assumptions; revising MDS and NHSN closeout workflows before CY 2027; confirming vendor readiness for the 45-day submission cycle; evaluating which non-FFS skilled stays will require all-payer MDS assessments; budgeting for EHR, staffing, training, and audit changes before October 2029; and strengthening internal controls over the two MDS-based VBP measures before the shortened snapshot dates take effect.

Reference pages: Final Rule PDF pp. 20, 68-74, 82-91, 101-102, 135-152, 166-177.