

The CMS SNF QRP All-Payer Expansion: What FY 2031 Means for Operators Choosing a Platform Now

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CMS finalized the extension of SNF QRP admission and discharge assessments to every resident — Medicare Advantage, Medicaid, managed Medicaid, VA, commercial, workers' compensation, and private pay. The platform criteria that decide who absorbs FY 2031 without losing clinician hours.

Update — August 28, 2026. This article was published while the change was still a proposal. CMS finalized it in the FY 2027 SNF PPS final rule (CMS-1843-F, 42 CFR Part 413, Federal Register, July 31, 2026, FR Doc 2026-15562): MDS data must be submitted on each resident receiving covered skilled care in a SNF regardless of payer, beginning with the FY 2031 SNF QRP. The same rule also finalized a separate change moving SNF QRP submission and correction deadlines from 4.5 months after quarter end to the 15th day of the second month after the end of the calendar quarter, beginning with the FY 2029 SNF QRP. Analysis below stands; the status is now final rather than proposed. See the operator readiness checklist and full citations.

The FY 2027 SNF PPS rulemaking contains a structural change to the Skilled Nursing Facility Quality Reporting Program that has been largely overshadowed by the more immediate Validation Program rollout. CMS extended SNF QRP reporting requirements to all payer types — not only traditional Medicare Part A — through two new assessment categories: the Other Skilled Care Admission Assessment (SCA, A0310B) and the Other Skilled Care Discharge Assessment (SCD, A0310I). Implementation begins with the FY 2031 SNF QRP; the change was proposed on April 7, 2026 (91 FR 17678) with comments due June 1 and finalized July 31, 2026.

Operators reading the proposal as a future problem are reading it wrong. The capital and platform decisions made in 2026 and 2027 — which EHR, which clinical data model, which AI layer, which integration posture — determine whether FY 2031 absorbs without disruption or arrives as a workforce crisis. This article frames the rule, the burden the industry is challenging, the platform criteria that decide outcomes, and where SeniorCRE fits.

The framing

Today, PPS admission and discharge assessments are a Medicare Part A obligation. Under the proposal, they become a universal screening and documentation discipline applied to every resident, every payer, every day of stay — with daily skilled-criteria monitoring sustained until skilled services end. The proposal does not add a form. It adds an operating cadence.

1. What the Rule Actually Requires

CMS proposes to require admission and discharge assessments for all residents , regardless of payer. Every resident — Medicare Advantage, Veterans Affairs, commercial insurance, Medicaid, managed Medicaid, workers' compensation, and private pay — must be evaluated against four skilled-care criteria:

- Need for skilled services — is a skilled clinician required to deliver or supervise the care?
- Daily necessity — are the services required on a daily basis?
- Inpatient-only SNF appropriateness — can the care be delivered only in a skilled nursing community as an inpatient?
- Medical necessity — is each service medically necessary and tied to the resident's condition?

In the accompanying CMS mock-up, two new item-set values appear under the PPS assessment classification fields: A0310B = SCA (Other Skilled Care Admission Assessment) and A0310I = SCD (Other Skilled Care Discharge Assessment). The instrument is the existing NP item set — the nursing home PPS subset of the MDS — applied to the non-Medicare skilled population. The PPS discharge item set termed NPE is reused for end-of-stay capture.

The structural consequence is a parallel assessment system for non-Medicare skilled residents: continuous skilled-status monitoring, daily documentation supporting that status, and a discharge assessment when skilled services end — applied across the entire census.

2. Why the Industry Says the Burden Estimate Is Low

CMS estimates annual industry burden at approximately \$88 million. The American Association of Post-Acute Care Nursing (AAPACN) has stated publicly that initial analysis suggests the actual figure will be materially higher. The basis for that view sits in AAPACN's 2025 NAC Work Study Time Report:

- A stand-alone PPS 5-Day assessment averages 56.92 minutes of nurse assessment coordinator time.
- A PPS Discharge assessment averages 32.93 minutes .
- Daily skilled-criteria review pulls unit managers, directors of nursing, bedside nurses,

direct care nurses, and therapists into the loop — all of whom already participate in clinical monitoring but would now carry an explicit documentation obligation.

CMS has suggested the burden is partly offset because many communities already complete 5-Day assessments for some Medicare Advantage plans, and because SNFs would no longer need to determine which residents require MDS submission.

AAPACN's counter is twofold: most MA plans do not require PPS Discharge assessments today, and current requirements vary widely across payers, so the "already doing it" framing materially understates the lift. The cumulative cost of applying skilled determinations at every admission and readmission — particularly after short hospital stays — compounds quickly across a typical census.

The deeper concern is workload displacement. In nursing practice, if it is not documented, it is considered not done. Universal daily skilled documentation pulls direct-care nurse hours into the chart and away from the resident. That is the burden AAPACN is asking CMS to reconsider.

3. What AAPACN Is Proposing as an Alternative

AAPACN has not finalized its recommendations, but its initial direction is clear: do not collect the same data twice. OBRA (Omnibus Budget Reconciliation Act) assessments are already conducted on all payer types and already capture the comprehensive functional, clinical, and cognitive picture that drives skilled-care determinations. Where the data already exists in the OBRA record, the SCA and SCD assessments should derive from it — not re-collect it.

The implication for technology buyers is direct. A platform that treats OBRA, PPS, SCA, and SCD as views of the same resident record can comply without additional data entry. A platform that treats each as a separate form will pass the cost of the rule through to nurses.

4. The FY 2031 Timeline Is a Capital-Planning Window, Not a Compliance Window

FY 2031 reads as distant. It is not. The realistic operator timeline:

- June 1, 2026: public comment deadline. Industry submissions shape the final rule.
- FY 2027 final rule: structural design of SCA/SCD finalized.
- FY 2028 — FY 2030: EHR vendors implement, operators design workflows, payers update contracts, MA plans align.
- FY 2031: all-payer reporting goes live.

A typical enterprise EHR replacement cycle in skilled nursing is 18 to 36 months from contract to portfolio-wide go-live. Operators who select a platform in 2026 or 2027 have one full implementation window before the rule lands. Operators who wait until 2029 are

signing for go-live concurrent with the regulatory deadline — the worst possible posture.

5. The Platform Criteria That Decide the Outcome

The all-payer expansion is a stress test for the senior housing & care technology stack. Five criteria separate platforms that absorb the rule from platforms that pass it through to nursing staff as workload.

Criterion 1: One governed operating record, not bolted-together modules

If MDS, OBRA, eMAR, CNA point-of-care, therapy, vitals, and payer all live in separate systems, the SCA and SCD assessments require new data entry. If they live in one governed operating record — Resident, Care Plan, Ledger, Shift, Property/Unit, Entity — the assessments derive from data already captured during normal care delivery. The first architecture is a forms factory. The second is a derivation engine.

Criterion 2: Payer-agnostic assessment scheduling

Most legacy systems wire MDS scheduling to Medicare Part A admission. The new rule requires scheduling tied to skilled status, not payer status. The platform must trigger an SCA when skilled criteria are first met for any payer, and an SCD when they end — independent of who is paying. Platforms that hard-code payer into the assessment scheduler will require structural changes to comply.

Criterion 3: Daily skilled-criteria evaluation as a background agent

Universal daily clinical review is the most expensive part of the rule. A platform that runs the four skilled criteria as a continuous background evaluation — flagging only residents whose status changed — replaces universal manual screening with exception-based clinician work. Without it, every nurse reviews every resident every day. With it, clinicians review only the small set the platform escalated.

Criterion 4: Documentation context pull-forward and voice capture

The 56.92-minute 5-Day benchmark and 32.93-minute discharge benchmark assume manual data entry. Two product capabilities directly compress those numbers: prior assessment context pull-forward (the chart pre-fills what is already known) and conversational voice capture (the nurse dictates the daily skilled-care note instead of typing it). Neither is exotic. Both materially change the per-resident time cost.

Criterion 5: Submission-pipeline parity for non-Medicare payers

The SCA and SCD assessments will need to flow into the existing CMS submission lane alongside PPS and OBRA submissions. Platforms with a single, monitored submission pipeline can extend it. Platforms that have a bespoke MA workflow, a separate Medicaid workflow, and a separate VA workflow will be assembling a fourth lane under regulatory deadline.

6. The Workforce Question: Hours Returned vs. Hours Consumed

AAPACN's concern is straightforward: the proposal would pull more than an hour per resident per day away from direct care into documentation. That is the implementation that platform choice should make impossible. The metric to evaluate any candidate platform against the rule is clinician hours returned per resident per day after FY 2031 go-live, not feature-count parity with the requirement.

The downstream workforce risk is moral injury — the well-documented harm to caregivers who repeatedly cannot deliver the care they trained to deliver because the chart consumes their shift. The all-payer expansion accelerates that risk in any community whose platform cannot derive, pre-fill, voice-capture, and escalate by exception.

7. Where SeniorCRE Fits

SeniorCRE is architected as one governed operating record across the entire stack — the six entities of Resident, Care Plan, Ledger, Shift, Property/Unit, and Entity — rather than as a stack of point modules. That architecture is what determines how the FY 2031 rule lands inside a community.

The MDS/RAI module (M25) already supports the full PPS item set — 5-Day, IPA, PPS Discharge — alongside OBRA assessments across all payer types. Adding the SCA and SCD item-set values to the assessment scheduler is configuration, not architectural change, because the underlying instrument is the same NP and NPE item sets the platform already runs. Context pull-forward pre-fills prior assessment data into new SCA and SCD forms, directly compressing the 56.92 / 32.93 minute benchmarks. The Conversational Clinical Workflow lets nurses dictate the daily skilled-care note rather than type it.

SeniorCRE AI runs the four skilled-care criteria as a continuous background evaluation across the census, surfacing only residents whose skilled status changed — replacing universal manual screening with exception-based work. Where OBRA data already contains the answer, the platform derives the SCA and SCD fields rather than re-asking — exactly the alternative AAPACN is asking CMS to allow. The QM Engine 2026 reconciles MDS-derived measures against the underlying chart before submission, eliminating the gap that drives QRP Validation Program failures. The Moral Injury Prevention layer triggers when added documentation pushes nurse workload past the 80% threshold, surfacing the staffing impact in real time so directors of nursing can act before clinicians burn out.

The Clinical ROI Calculator (/clinical-roi-calculator) lets operators model the per-

community cost of the rule against CMS's \$88M industry estimate — useful both for capital planning and for substantiating public comments to CMS by June 1.

What changes when the all-payer expansion lands on one governed operating record

- Skilled-criteria evaluation runs in the background across every resident, surfacing only exceptions.
- SCA and SCD assessments derive from OBRA, eMAR, CNA point-of-care, and vitals — no double entry.
- Voice-captured daily skilled-care notes replace typed documentation for direct-care nurses.
- Submission flows into the existing CMS pipeline; non-Medicare lanes do not require a parallel build.
- Workload monitoring catches displacement before clinician hours collapse.

8. The Platform Evaluation Checklist for Operators Choosing Now

For operators in the middle of an EHR or operating-platform decision in 2026 or 2027, the all-payer expansion adds five concrete questions to the RFP:

- Architecture: Is MDS, OBRA, eMAR, CNA point-of-care, therapy, vitals, and payer data in one model, or in separate systems integrated by middleware?
- Scheduling: Can the assessment scheduler trigger on skilled-status change for any payer, or is it hard-coded to Medicare Part A?
- Derivation: Can SCA and SCD fields be derived from existing OBRA, clinical, and operational data, or do they require re-entry?
- Workload impact: What is the documented clinician-time delta per resident per day after FY 2031 go-live?
- Submission pipeline: Is there a single monitored CMS submission lane, or separate workflows by payer?

9. What to Do Before June 1

Operators have two near-term actions. First, submit a substantive comment to CMS that quantifies the burden using community-specific data — the AAPACN NAC Work Study Time Report provides the per-assessment benchmark; multiplying it by census, admission cadence, and payer mix yields a defensible cost figure. Second, add the five platform-evaluation questions above to any active EHR or operating-platform RFP. The cost of choosing wrong is paid in nurse hours from FY 2031 onward.

The CMS SNF QRP all-payer expansion is the clearest test yet of whether senior housing & care technology is a forms factory or an operational substrate. The platforms that win the next decade are the ones that turn this rule into a configuration change. The platforms that lose are the ones that turn it into a workforce crisis.

Related research: CMS SNF QRP · CMS FY 2027 SNF PPS Proposed Rule · AAPACN · Skilled Nursing News · iQIES Provider Preview Reports

See how SeniorCRE makes this operational

SeniorCRE unifies clinical, financial, and operating signals into one platform — so the analysis above becomes a daily workflow, not a one-time report.

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