Date: June 1, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1843-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via the Federal eRulemaking Portal: http://www.regulations.gov

Re: Comments on the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027 (CMS-1843-P), Request for Information: SNF QRP Quality Measure Concepts Under Consideration for Future Years (Advance Care Planning)

The LTPAC Health IT Collaborative (the Collaborative) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) in the Fiscal Year (FY) 2027 Skilled Nursing Facility (SNF) Prospective Payment System Proposed Rule (CMS-1843-P), published in the Federal Register on April 7, 2026 (91 FR 17678). Specifically, we offer comments on the RFI regarding potential quality measure concepts related to Advance Care Planning (ACP) under consideration for future adoption in the SNF Quality Reporting Program (SNF QRP).

The LTPAC Health IT Collaborative was founded in 2005 as an invitation-only group of national stakeholder associations, organizations, and subject matter experts dedicated to advancing meaningful, effective, and accessible health information and technology policies, strategies, standards, resources, products, and services that enhance the delivery of coordinated, quality care for persons with chronic and/or complex needs. Our membership spans clinical, provider, technology, and research organizations with specific expertise in Long-Term and Post-Acute Care (LTPAC).

## Overarching Recommendations

The LTPAC Health IT Collaborative offers strong support for CMS's pursuit of an Advance Care Planning quality measure for the SNF QRP. A well-designed ACP measure is the right move, it is the accountability mechanism the SNF sector needs to move advance care planning from a routine admission task to a continuous, resident-centered clinical practice. Our recommendations are offered in that spirit, and focus on ensuring the measure drives genuine improvement rather than surface-level compliance.

The Collaborative urges CMS to:

1. **Strengthen the regulatory foundation** beneath the measure by clarifying key provisions of 42 CFR Part 483, including the definition of "Resident Representative," the scope of advance healthcare directives to include PMOs and POLST, ACP documentation requirements in the resident assessment and care plan, and ACP integration across all clinical service domains, medical records, QAPI, and compliance programs, so the measure reflects real quality, not documentation formality
2. **Design for meaningful outcomes**, not process checkboxes, assessing whether care is actually consistent with residents' documented preferences, with concrete use cases such as DNR adherence and avoidance of unwanted hospitalization, and avoiding reintroduction of an MDS checkbox that CMS previously removed for lacking meaningful quality differentiation
3. **Align measure design** with existing standards infrastructure, including the DEL, USCDI, and the PACIO Project's Advance Healthcare Directive Interoperability FHIR Implementation Guide, and require FHIR-compliant, electronically exchangeable ACP documentation as a condition of measure compliance
4. **Support SNF health IT readiness** through a field-wide readiness assessment and a scalable, adequately resourced technical assistance program that expands the QIO 13th SOW model to reach the full range of SNF providers, with phased implementation timelines
5. **Integrate health equity stratification** into measure specifications and public reporting;
6. **Ensure data integrity for the proposed 45-day MDS submission deadline** by establishing a clear, codified correction process, and require interoperable FHIR-based standardized reporting for the all-payer MDS expansion across all Medicare subcontractors

The SNF community has the relationships, the time with residents, and the clinical infrastructure to make ACP a genuine cornerstone of person-centered care. What the sector needs is a quality measure, and a regulatory framework, that makes the expectations clear and provides the structure to close the gap between aspiration and practice. The Collaborative looks forward to continued partnership with CMS in advancing this goal.

## Overview: Support for the ACP Quality Measure Concept With Important Caveats on Approach

The Collaborative strongly supports CMS's pursuit of an Advance Care Planning quality measure for the SNF QRP. A well-designed ACP quality measure is not only appropriate, it is necessary. Advance care planning, when implemented with fidelity, is among the most powerful tools available to ensure that residents receive care that reflects their own values, goals, and preferences. SNF providers care for some of the most vulnerable individuals in the healthcare system at some of the most consequential junctures of their lives. The SNF setting, with its interdisciplinary team model, its care conference process, and its extended, relationship-based care, is uniquely positioned to make ACP a continuous, integrated part of clinical practice, not a one-time intake task.

The Collaborative supports CMS's interest in Advance Care Planning as a meaningful quality measure concept for the SNF QRP. Advance care planning, when implemented with robust health information technology (health IT) support, enables SNFs to align care delivery with the documented values, preferences, and goals of residents and their families. This is consistent with the Collaborative's core commitment to person-centered care with longitudinal health records and our longstanding advocacy for health IT tools that facilitate coordinated, effective care across care settings and transitions.

However, our support is contingent on how the measure is designed and operationalized. We have significant concerns about an approach that would simply add a documentation checkbox to the Minimum Data Set (MDS). CMS removed an ACP documentation item from the MDS when transitioning from version 2.0 to 3.0 precisely because it produced a ceiling effect, nearly universal "yes" responses, that provided no meaningful quality differentiation and no actionable data. Reintroducing a similar checkbox item would repeat that error, and would add administrative burden without generating the outcomes-oriented quality information that CMS, providers, and patients need. With approximately 4.5 million SNF admissions annually, even a one-minute-per-admission checkbox exercise amounts to 4.5 million staff-minutes lost per year to a process that does not improve patient care or yield meaningful quality information.

We recognize that CMS has stated it will prioritize evidence-based outcome measures that promote person-centered care practices. We strongly concur with this priority. We urge CMS to ensure that any ACP measure adopted for the SNF QRP is designed with the capabilities and constraints of SNF clinical workflows and health IT environments firmly in mind, and that it is designed from the outset as a meaningful outcome measure, not merely a process documentation requirement.

## I. Foundational Principle: Strengthen the Regulatory Framework Alongside the Measure

The existing federal regulatory framework governing SNF practice, primarily 42 CFR Part 483, Subpart B, reflects a sound intent. It speaks to resident rights, individualized care planning, quality of life and care, and advance directives. What is missing is the explicit, actionable language that integrates ACP into the full continuum of SNF care delivery: from admission through discharge, and across every clinical service domain in between. The current regulations describe the destination but do not provide the map. As a result, a checkbox culture has taken hold, not because providers stopped caring, but because nothing in the existing framework demanded more.

A new ACP quality measure layered on top of this fragmented foundation risks measuring surface-level compliance rather than meaningful, person-centered practice. The Collaborative urges CMS to undertake targeted regulatory clarifications in parallel with quality measure development, so that the measure has accurate, verifiable, clinically grounded data to draw from and reflects real quality rather than documentation formality.

Specifically, the Collaborative recommends CMS consider the following priority regulatory actions as part of its ACP quality measure development effort:

- **Align the definition of "Resident Representative" (42 CFR §483.5) with jurisdictionally-appropriate legal medical decision-making authority.** The current broad definition creates structural ambiguity that allows individuals without appropriate legal standing to make care decisions that may contradict a resident's documented preferences. Each SNF admission should trigger the creation, review, or update of a Durable Medical Power of Attorney (DMPOA) or equivalent legal document, with the term "Resident Representative" either removed or made explicitly synonymous with that legally designated authority. Without this alignment, any ACP quality measure will be built on a definitional foundation that may not reflect the resident's actual legal designations.
- **Expand "advance directive" language throughout 42 CFR Part 483 to "advance healthcare directive,"** encompassing portable medical orders (PMOs), POLST forms, mental health/psychiatric advance directives, and other jurisdictionally-recognized instruments. Portable medical orders are among the most actionable ACP tools available to SNF residents — particularly at points of acute clinical change — and their omission from current regulatory language leaves a critical gap in the framework.
- **Require ACP documentation review as a component of the comprehensive resident assessment (42 CFR §483.20).** Currently, no requirement exists to assess the presence, currency, or completeness of ACP documents as part of the formal admission assessment. This baseline must be established before a quality measure can meaningfully capture whether a resident's ACP status has been assessed, documented, and incorporated into care.
- **Require that ACP documentation serve as the explicit foundation for the comprehensive care plan and discharge planning (42 CFR §483.21).** ACP preferences should govern care delivery across every clinical service domain — including pharmacy, behavioral health, rehabilitation, nutrition, and dental services (42 CFR §§483.40, 483.45, 483.55, 483.60, 483.65) — and clinical disagreements with documented preferences should trigger a formal ACP consultation with documented outcome.
- **Require ACP documentation (or documented declination of ACP services) as a mandatory component of the medical record (42 CFR §483.70(h)).** Without this requirement, there is no structural assurance that the MDS coding of ACP status aligns with the clinical record, or that the care plan reflects the resident's documented preferences.
- **Incorporate ACP concordance into QAPI processes (42 CFR §483.75) and establish ACP non-conformance as a compliance and ethics matter (42 CFR §483.85).** Providing treatment contrary to a resident's documented preferences raises serious ethical and legal obligations. Making ACP adherence a QAPI priority gives SNFs the internal accountability framework needed to sustain improvement over time.
- **Require that ACP work completed through hospice services be communicated to and integrated by the SNF (42 CFR §483.70(n)).** Where hospice and SNF care overlap, resulting ACP documents should be incorporated into the SNF medical record and care

plan to ensure continuity and goal-concordant care.

These regulatory actions do not impose new burdens on providers, they clarify expectations that most providers already aspire to meet. They give the sector the structure it needs to make ACP a consistent, verifiable clinical practice, and they give CMS's forthcoming quality measure the solid foundation it requires to drive real improvement.

## II. Key Recommendations on ACP Measure Design

### A. Design for Meaningful Outcomes Not Process Checkboxes

CMS should design any ACP quality measure to assess whether SNF residents' care actually aligns with their documented goals and directives, not merely whether a document was filed at admission. CMS removed an ACP documentation item from the MDS when transitioning from version 2.0 to 3.0 precisely because it produced a ceiling effect, with nearly universal "yes" responses that provided no meaningful quality differentiation. Reintroducing a similar checkbox would repeat that error, adding administrative burden without generating actionable quality information. With approximately 4.5 million SNF admissions annually, even a one-minute-per-admission checkbox exercise amounts to 4.5 million staff-minutes lost each year to a process that does not improve care.

The Collaborative recommends that CMS pursue an outcome-based measure that assesses adherence to patient directives whether care decisions are actually consistent with residents' expressed preferences. Concrete use cases that could inform outcome measure design include: DNR adherence (was a resident with a documented DNR resuscitated without clinical justification?); avoidance of unwanted hospitalization (was a resident transferred to a hospital despite a documented preference to remain in place?); and care plan alignment at transitions (was ACP documentation transmitted electronically to the receiving care setting and documented as reviewed?). These outcomes are measurable, clinically meaningful, and tied directly to whether resident preferences are honored in practice.

If CMS determines that a process measure is appropriate as a transitional step, the Collaborative strongly recommends that it be explicitly time-limited, include meaningful data quality requirements, and include a clear, timeline-bound pathway toward the outcome-oriented measure described above, consistent with CMS's broader commitment to shifting quality programs toward outcomes.

### B. Align Measure Design with Existing Standards and Data Infrastructure

Any ACP quality measure should leverage structured, computable data elements that can be captured within certified EHR technology and exchanged electronically across care settings. The Collaborative recommends that CMS build on existing infrastructure already available in the SNF setting and beyond, including the Data Element Library (DEL) and USCDI concepts such as Care Experience Preferences, Treatment Intervention Preferences, and Portable Medical Orders. CMS should specifically align with the PACIO Project's Advance Healthcare Directive Interoperability FHIR Implementation Guide, which provides a standards-based, structured framework for representing, exchanging, and verifying ACP information across care settings.

The IMPACT Act of 2014 requires that assessment data be standardized and interoperable to allow for exchange among post-acute care and other providers. Any ACP measure adopted for the SNF QRP should advance, not undermine, that mandate. Standardized, electronic storage of ACP data is foundational not only for interoperability and care coordination, but for quality measurement itself: it is the prerequisite for developing meaningful electronic quality measures (EQMs/eCQMs) and the enabling condition for AI-assisted quality monitoring tools that can proactively identify when directives are not being followed or when ACP information fails to accompany a care transition.

**C. Ensure Cross-Setting Interoperability and Longitudinal Access**

Advance care planning is a continuous, longitudinal process, not a document created once and filed. ACP information must be accessible and current across the full care continuum, from hospital to SNF to home health and community settings, accompanying the resident through every transition and handoff. The Collaborative urges CMS to coordinate with ONC and the PACIO Project to ensure that any SNF QRP ACP measure reinforces a connected, interoperable approach to ACP documentation. CMS should require that ACP documentation be stored in a FHIR-compliant, electronically exchangeable format as a condition of measure compliance, so that the document is never stranded in a single setting's records system.

**D. Address Health IT Readiness and Support SNF Capacity**

Significant variation persists in health IT adoption, EHR capability, and interoperability readiness across SNF providers. Research on SNF health IT maturity documents substantial differences across facility size, ownership type, and rural/urban geography. More than half of SNFs in the United States are small, independent operators who face disproportionate challenges in health IT adoption and staffing stability.

CMS should conduct a field-wide readiness assessment of the SNF sector's capacity to capture and exchange structured ACP data before finalizing measure requirements. Equally important, CMS should develop a scalable, well-resourced technical assistance program, building on the QIO 13th Statement of Work framework, which the Collaborative endorses for its locally tailored, one-on-one support model, but which in its current form is limited to the lowest-tier adopters and cannot achieve the scale needed across the sector. CMS should consider phased implementation timelines that give facilities with genuine readiness gaps sufficient runway to update systems and workflows before measure compliance is assessed or tied to payment consequences.

**E. Address Health Equity in Measure Design and Reporting**

Any ACP quality measure for the SNF QRP should include equity stratification to identify and address disparities in ACP engagement across racial and ethnic groups, persons with limited English proficiency, persons with cognitive impairment, and residents in rural or underserved communities. Health equity considerations should be incorporated into both the measure specification and public reporting requirements to ensure that ACP quality improvement reduces, rather than exacerbates, existing disparities.

**F. Engage Residents, Families, and Caregivers in Measure Development**

Measure development should meaningfully include the perspectives of SNF residents, families, and caregivers. Person-centered measurement requires that those most affected have a voice in defining what quality ACP looks like in the SNF setting. The Collaborative recommends that

CMS's measure development contractor engage patient and family advisory panels — particularly those representing aging adults with chronic and complex needs — in Technical Expert Panel (TEP) processes and measure testing phases.

## III. Additional Considerations: Data Submission Timelines and All-Payer MDS Expansion

While not the primary focus of this RFI response, the Collaborative wishes to note concerns related to two other proposals in the FY 2027 SNF PPS proposed rule that intersect with our health IT priorities.

**Shortened MDS Data Submission Deadlines.** CMS proposes, beginning with FY 2029, to shorten the MDS data submission deadline from approximately 4.5 months to 45 days following the close of each calendar quarter. While the Collaborative supports the goal of making quality data more timely and actionable, CMS should evaluate whether all SNFs, particularly small, independent, and rural facilities, have the capacity to meet compressed deadlines without risking data accuracy. Workforce instability, especially MDS coordinator turnover common in smaller facilities, leaves little margin under a 45-day window. CMS should also clarify the data correction process: if errors are identified after submission, what is the pathway to correction, and how will CMS protect the integrity of quality measure data used for public reporting and payment determination? A clear, streamlined correction process is essential and should be codified alongside any shortened deadline.

**All-Payer MDS Submission Requirement.** CMS proposes to require MDS data submission for all residents regardless of payer beginning with FY 2031. The Collaborative supports efforts to develop a more complete picture of care quality across all SNF residents, provided the resulting data accurately reflects quality that is under SNF providers' control, does not take away from direct patient care, and is not confounded by payer policy variation or resident population differences. CMS should require that all-payer MDS reporting use an interoperable, FHIR-based standardized format, and should extend this standardization requirement to all Medicare subcontractors and related entities in the data ecosystem to ensure consistency. CMS should provide adequate lead time and clear guidance as payer rules evolve, so SNFs can update systems and workflows accordingly.

## Conclusion

As stated in the beginning of this comment letter, the Collaborative offers strong support for CMS's pursuit of an Advance Care Planning quality measure for the SNF QRP. A well-designed ACP measure is the right move, it is the accountability mechanism the SNF sector needs to move advance care planning from a routine admission task to a continuous, resident-centered clinical practice. Our recommendations are offered in that spirit, and focus on ensuring the measure drives genuine improvement rather than surface-level compliance.

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We look forward to continued dialogue with CMS on these and related health IT priorities for the SNF and broader LTPAC settings.For questions regarding these comments, please contact the LTPAC Health IT Collaborative Convener, Michelle Dougherty, at leaders@ltpachit.org or via our website at www.ltpachit.org.

Respectfully submitted,

**The LTPAC Health IT Collaborative**

*For a list of LTPAC Health IT Collaborative members, please visit www.LTPACHIT.org*