



May 31, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically to <http://www.regulations.gov>

Re: CMS-1779-P. Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024

Dear Administrator Brooks-LaSure:

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the opportunity to comment on this Medicare skilled nursing facility (SNF) payment proposed rule, which is vital to the health, safety, and well-being of nursing home residents and important to their family caregivers who may often assist with their loved ones' care.

Our comments focus on the SNF Quality Reporting Program (QRP), the SNF Value-Based Purchasing Program (VBP), health equity, important opportunities to strengthen the recognition, inclusion, and support of family caregivers in Medicare, the impact of the Patient Driven Payment Model (PDPM) on beneficiaries' access to appropriate SNF services, and the process regarding waiver of a hearing and reduction of civil money penalties.

SNF Quality Reporting Program (QRP)

Proposed New and Revised Measures

Healthcare Personnel COVID-19 Vaccination Measure and Patient/Resident COVID-19 Vaccination Measure

AARP supports the proposed modifications to the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 vaccine) measure. Throughout the COVID-19 pandemic, nursing home residents have been a disproportionately vulnerable population with high rates of morbidity and mortality from COVID-19. Recognizing the expiration of the public health emergency declaration on May 11, 2023, AARP continues to believe that adherence to infection prevention and control measures is essential to the health, safety, and well-being of nursing home

staff, residents, and their loved ones. COVID-19 vaccinations and boosters have been effective tools in preventing the severe consequences of COVID-19, including the high number of deaths we have seen among nursing home and other long-term care facility residents and staff during the pandemic. Access to transparent, complete, and easily understandable information is also an essential tool for nursing home residents and their family caregivers in support of informed decision-making. To this end, AARP continues to believe the HCP COVID-19 vaccine measure, and the public display of the results of such measure on Care Compare in an easy-to-understand format, provides vital information for current and prospective residents and their family caregivers. AARP agrees that to ensure the accuracy and usefulness of the information, the measure needs to be updated, as proposed, to explicitly specify for HCP to receive primary series and booster vaccine doses in a timely manner to align with the recommendations on bivalent booster doses, including being up to date.

Similarly, AARP believes the COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date (Patient/Resident COVID-19) measure would be a relevant and valuable addition to the SNF QRP measure set and supports its adoption. This measure would provide another source of valuable information to current and prospective nursing home residents and their family caregivers in their decision-making process. Specifically, the measure reports the percent of stays in which residents in a SNF are up to date on their COVID-19 vaccinations per the CDC's latest guidance. Verified vaccination status for both staff and residents should be key elements of each facility's infection control and prevention plan. AARP supports publicly reporting selected results on Care Compare, while protecting resident privacy, to aid beneficiaries and families in selecting a facility.

AARP continues to emphasize the importance of including information on these measures on Care Compare in a transparent and easily understandable manner. Therefore, data displayed on Care Compare on the HCP COVID-19 vaccine and Patient/Resident COVID-19 vaccine measures should be coordinated with existing measures of staff and resident COVID-19 vaccination and rates to avoid confusion or duplication. It is vital that consumers, residents, and caregivers understand and can interpret what data is being represented. We also urge that reported data include demographic information to highlight potential disparities similar to those already uncovered about COVID-19 variation within facilities and among residents. CMS noted in the preamble of the proposed rule the disparity in vaccination rates as well as in receipt of boosters. To help assess and address health equity gaps, strong consideration should also be given to providing results to facilities that are stratified for race, ethnicity, and other social risk factors based on information submitted by facilities.

As nursing homes, their residents, and staff transition to a post-public health emergency framework, and as COVID-19 persists and evolves, infection prevention and control measures continue to be integral in nursing homes and other long-term care settings. AARP is concerned to learn that CMS is no longer planning to require COVID-19 vaccination for staff of Medicare and Medicaid-certified providers and suppliers. Vaccination of nursing home residents and staff has been key to improved COVID-19 outcomes among residents. We suggest CMS revisit this issue moving forward. We urge the federal government to work with states, nursing homes, and other entities, as needed, to ensure that facilities can access and administer vaccines on a continuing

basis, and to ensure that masks continue to be readily available for residents, staff, family caregivers, and other visitors.

Discharge Function Score (DC Function) Measure

CMS is proposing adoption of the DC Function measure in both the SNF QRP and SNF VBP. The measure is a functional measure for use across all post-acute care (PAC) settings that would incorporate both the domains of self-care and mobility. Maintaining and/or improving beneficiary functional status is a foundational goal of PAC for beneficiaries and providers. AARP continues to believe that measures of functional status have value for provider performance improvement and for informed decision making by individuals and families. AARP therefore supports continued work by CMS focused on self-care and mobility measures.

In considering a measure for functional status for adoption in the SNF QRP or SNF VBP – and because individuals and families place high value on optimal functional outcomes – we recommend that the measure have beneficiary and family caregiver input (e.g., as members of or advisors to the Technical Expert Panel) and be designed in a way that facilitates easily understood public reporting of results on Care Compare. We also suggest the use of beneficiary and family caregiver focus groups or similar testing of potential measures to provide valuable feedback before measures are finalized. We note and appreciate that CMS held a Patient and Family Engagement Listening Session to seek and consider resident and family caregiver feedback on this measure. We also suggest that CMS examine measure(s) that would capture both maintenance, as well as improvement, in functional status. Both are important to include. See also our comments under *Guiding Principles for Selecting and Prioritizing SNF Quality Measures and Concepts* that are relevant here.

CoreQ: Short Stay Discharge Measure

CMS is proposing to adopt as part of the SNF QRP measure set the *CoreQ: Short Stay Discharge* measure, which is based on resident reported data and assesses the level of satisfaction among SNF residents. AARP has repeatedly supported the addition of experience of care measures to the SNF and other PAC settings. It is important that such a measure is based on resident reported data, supports person-centered care, and captures resident data regardless of payer type. We firmly believe that this type of measure is important, relevant, and applicable to SNFs. However, we express strong concern with the use of the CoreQ Short Stay Discharge survey and firmly believe that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Nursing Home Discharged Resident survey is clearly superior to, and more relevant than, the CoreQ survey for this purpose. Resident experience data is already collected using CAHPS resident experience surveys in other settings, such as home health, hospice, and hospital, and the CAHPS Nursing Home survey: Discharged Resident Instrument was developed for short-stay SNF residents.

The CAHPS survey is the product of a public, rigorous, and independent development process co-sponsored by CMS that includes literature review, resident and family focus groups, user

group testing for comprehensibility, and field testing for reliability and validity.¹ Potential responses are more objective and balanced across positive, neutral, and negative choices. We note that in CoreQ, the responses to the questions are Poor, Average, Good, Very Good, or Excellent (one negative, three positive, and one potentially neutral). This contrasts with more objective or neutral surveys that include two negative, two positive, and one neutral response. Specific, actionable aspects of resident experience are queried (e.g., response time of facility staff to calls for help). In comparison, the CoreQ survey consists primarily of summative satisfaction ratings (e.g., overall rating of care) rather than actionable queries and only one of five response choices is negative, as noted above. In the FY 2022 SNF PPS final rule, CMS reported that commenters found CoreQ questions too vague and the overall survey to be too limited to sufficiently capture patient experience for quality measurement. In addition, the Nursing Home CAHPS Survey provides more complete and comprehensive information about a resident's (or family member's) experience. AARP also notes the recommendation by the National Academies of Sciences, Engineering, and Medicine for adoption of the CAHPS survey in its 2022 report on nursing home quality.²

If the CoreQ survey is used, AARP urges CMS to ensure that SNF residents who receive assistance from family caregivers in filling out their survey will not have their responses excluded from the measure data. Family caregivers are often vital in assisting SNF residents, and a resident's voice should not be discounted for receiving assistance from their caregiver in filling out the survey. AARP is also concerned that residents discharged to another hospital, SNF, psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or hospice will not be considered questionnaire-eligible residents for purposes of collecting data on the measure. We believe the experience in care of these individuals should also be included in the experience data collected and assessed by the measure.

RFI on Guiding Principles for Selecting and Prioritizing SNF Quality Measures and Concepts

The proposed rule identifies guiding principles for inclusion and maintenance of measures in the future SNF QRP measure set. The principles described intend for the measures to be meaningful to beneficiaries and family caregivers, not impose undue burden on SNFs, align with PAC program goals, and be readily operationalized. CMS seeks information on these principles and existing gaps in the SNF QRP measure set for purposes of addressing those gaps.

AARP supports the principles of the established National Quality Strategy (NQS) – supporting a high-value health care system promoting quality outcomes, safety, equity, and accessibility for all individuals – which inform the analysis for inclusion in the SNF QRP measure set.

AARP strongly recommends as a guiding principle that only measures for which data elements are clearly defined, valid, and well standardized be prioritized for the SNF QRP measure set. We also strongly encourage CMS to give high priority to measures developed in response to issues

¹ Agency for Healthcare Research and Quality, 2018. Development of the CAHPS nursing home resident surveys. <https://www.ahrq.gov/cahps/surveys-guidance/nh/resident/Development-Resident-Surveys.html>.

² National Academies of Sciences, Engineering, and Medicine 2022. The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26526>.

identified through review and analysis of resident and family input, Quality Improvement Organization (QIO) outreach, ombudsmen investigations, and surveyor reports. Generally, we strongly support measures that are meaningful to SNF residents and their family caregivers and which emphasize resident reported outcomes and support shared decision-making and health equity. We urge that guiding principles include the collection of demographic data, taking into account resident and family caregiver input, and results in transparent information that is informative to beneficiaries and caregivers. AARP also supports the principle that SNF performance measures should neither exacerbate nor induce unwanted responses to the payment system and mitigate adverse incentives of the system. For example, we have previously noted concerns expressed by others about accuracy and reliability of current PAC functional status measures, given the inherent conflict of interest created when the same assessment data are used for measure performance calculations and for case-mix adjustment to establish payments to PAC providers³. To help address such concerns, guiding principles in measure design should discourage upcoding and gaming. Consumer-reported outcome measures for self-help and mobility could mitigate such behaviors and we encourage CMS to explore their development.

AARP believes there is an existing measurement gap related to support for family caregivers, including caregiver status. AARP strongly supports the addition of Caregiver Status to the list of standardized patient assessment data elements (SPADEs) required for reporting by SNFs and other PAC providers. This data point would identify whether the beneficiary has a family caregiver (who may or may not be the next of kin) and identify that individual to the facility, including contact information (with consent of the resident and the family caregiver). Family caregivers (defined broadly) are important sources of information about individual preferences, can contribute observations about SNF resident status that are not readily apparent to facility staff, and provide essential psychosocial support. Involving the caregiver during the discharge planning process can help the beneficiary make a smooth transition home or to the next provider setting. The absence of an identifiable caregiver also may serve as a marker for other social risk factors that influence individual outcomes (e.g., social isolation) and a valuable element for use in stratified performance reports for facilities. It also provides an opportunity to identify and provide needed support for a family caregiver, such as education and training, especially around care transitions. AARP encourages CMS to consider adding SPADEs for education level and income.

Relatedly, family caregivers should be identified in electronic and paper records so they can appropriately be part of their loved one's care team if care and support depends on having a family caregiver. Family caregivers can impact the resident's care, outcomes, and quality of life. Their identification facilitates engagement, communication, and coordination with the caregiver, as well as the provision of caregiver support, as appropriate. Including this information would be an important step for further development of quality measures related directly to family caregivers.

³ Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. Chapter 7: Skilled Nursing Facility Services, pp 206-208. March, 2021.

Health Equity Update

AARP applauds CMS' continuing efforts to advance health equity and we encourage the rapid development and adoption of measures of social determinants of health (SDOH) into the SNF QRP, potentially using the seven assessment data elements (race, ethnicity, preferred language, need for interpreter, health literacy, transportation, and social isolation) collected in the SNF Minimum Data Set (MDS) resident assessment instrument. AARP previously supported the addition of the SDOH category of SPADEs and continues to believe that the collection of this information during required assessments of SNF residents will enhance holistic care, call attention to impairments to be mitigated or resolved, and facilitate clear communication between residents and providers. The use of such collected data could allow for examination of SNF performance stratified for factors associated with health care disparities, such as race and ethnicity.

Proposed Public Reporting of the Transfer of Health (TOH) Information to the Provider – Post-Acute Care (PAC) Measure and Transfer of Health Information to the Patient – PAC Measure Beginning with the FY 2025 SNF QRP

CMS adopted these two assessment-based measures in the FY 2020 SNF final PPS rule. After delayed compliance dates for collecting and reporting due to the COVID-19 public health emergency (PHE), data collection for the measures will begin with residents discharged on or after October 1, 2023. CMS proposes to publicly display four rolling quarters of the data received, initially using data on discharges from January 1, 2024, through December 31, 2024, with public display of the data for the measures beginning with the October 2025 Care Compare refresh.

These measures track the transfer of vital information (i.e., current, reconciled, medication lists) during SNF transitions between transferring and receiving providers. AARP acknowledges the importance of such measures and supports prompt implementation. However, we emphasize the need for CMS to take such steps as are necessary to ensure that the current medication list is provided to the resident and family/caregivers whenever and wherever the SNF discharges a resident (other than through death). Also, we repeat our prior recommendation that the data element for the TOH-Patient measure should be clear that if a Medicare beneficiary has a family caregiver that individual should receive the medication list if the beneficiary and family caregiver consent, even if it is also provided to the patient. Family caregivers are often involved in assisting the person they are caring for with their medications. In addition, for the TOH-Patient measure, it is important that the resident, family, or caregiver be given a chance to ask questions about the medication list to ensure they understand it.

SNF VBP

Quality Measures Proposals

CMS proposes the adoption of the Total Nursing Staff Turnover measure beginning with the FY 2026 program year. AARP is very supportive of measures that assess SNF staffing trends and staffing turnover. Along with staffing patterns, turnover rates may indicate quality and safety

issues as well as equitable and good treatment – or not – of employees by the facility. We note that turnover among clinical and nonclinical staff is particularly disruptive to optimal care for SNF residents with dementia. We, therefore, support nurse staff turnover as a high impact quality measure for the SNF VBP Program. We also support that the Total Nursing Staff Turnover measure is already used in the Five-Star Quality Rating System. We believe that the transparent and auditable PBJ staff reporting system should allow for comprehensive and accurate turnover data collection. AARP is concerned, however, about including nursing staff with administrative only duties rather than focusing the measure on direct resident care nursing staff. We encourage CMS to ensure that this measure reflects actual hours spent providing direct care to residents. Consumers will intuitively assume that nurse staffing measure results are for nurses devoted to resident care rather than to administrative responsibilities. We also suggest distinguishing between voluntary and involuntary turnover.

AARP also urges CMS to consider development of a measure focused on resident “dumping” – the practice of inappropriately or abruptly discharging or transferring a resident, including when a facility no longer wants to meet the resident’s needs. We are hearing about the occurrence of such events with increasing frequency, particularly involving residents with dementia. We urge CMS to explore this topic with stakeholders with the goal of developing an applicable direct or proxy measure. Factors that CMS could consider include complaints regarding inappropriate discharges and transfers, the extent of dumping behaviors and patterns of occurrence related to resident characteristics (e.g., dementia diagnoses) and facility attributes (e.g., Medicaid-dependent), and above-average interfacility transfer rates. We understand that facility-initiated transfers and discharges remain a top complaint to long-term care ombudsman programs across the country.

Health Equity Adjustment

CMS proposes a health equity adjustment (HEA) beginning with the FY 2027 program year. The HEA would be calculated using a methodology that considers both the SNF’s performance on the SNF VBP Program measures, and the proportion of residents with dual eligibility status (DES) out of the total resident population in a given program year at each SNF. Skilled nursing facilities that serve a higher proportion of DES residents and that perform well on quality measures would receive a larger adjustment.

AARP supports that the approach proposed takes into account performance as well as the extent to which a facility serves underserved populations. AARP firmly believes that ensuring health care equity promotes better quality for all older Americans, and recognizes the need to ensure resources are provided to facilities in a manner that allows for improved quality of care for underserved populations.

CMS requests comment on the use of DES to measure the proportion of residents who are underserved. AARP recognizes that DES data, at present, is available and familiar within the SNF setting, and may be an appropriate measure for now. However, DES does not reflect many other social risk factors that have equal or even greater effect on resident outcomes, and it does not reflect bias and discrimination that some populations may encounter which affect access,

care, and outcomes. Therefore, we agree that future consideration should also be given to other measurements.

Request for Information (RFI): Health Equity Approaches Under Consideration for Future Program Year

In addition to its HEA proposal, CMS requests comment on other ways to incentivize the achievement of health equity in the SNF VBP Program, such as focusing specifically on reducing disparities to improve care for all populations, including residents who may be underserved, and ways to assess improvements in health equity in SNFs.

AARP commends CMS for its sustained commitment to exploring issues of health equity and care disparities in the SNF VBP program specifically, and across its quality program portfolio generally. We agree the SNF VBP program should incorporate and reward the consistent delivery of high-quality care to all SNF residents regardless of their demographic and social risk factors. We remain committed to working with CMS and other stakeholders to ensure all our nation's seniors who seek care in Medicare-certified SNFs can achieve optimal and equitable health outcomes.

CMS specifically seeks comment on demographic variables and social risk indicators that would be most appropriate for assessing disparities and measuring improvements in health equity in the SNF VBP Program. AARP recommends that variables be required to have clear, standardized definitions and be meaningful to SNF residents and their family caregivers as determined through a formal and transparent process for obtaining their input. Variables chosen for investigation should in general have robust, established data sources. We encourage CMS to consider capturing variables and indicators among Medicare and Medicaid beneficiaries, for which correlations with care disparities have been well-documented, but for which there is limited person-level data available across CMS reporting systems. We also recommend for your review the set of principles we developed for race and ethnicity metrics based upon our experiences with stratified tracking of state-level COVID-19 metrics.⁴ AARP recognizes the strong value of patient-reported data, but also acknowledges there may be limited availability of such data in the current quality program portfolio. As we have noted previously, there is a community effect that has been demonstrated for SNFs, such that a facility located in a resource-poor community or one that has been underinvested in is more likely to struggle with quality measures and fiscal sustainability.⁵ This community effect can unveil itself in several ways for a facility, such as fewer workers who can access the facility or want to work there or fewer transportation and housing options for workers. Therefore, CMS should consider how the community could impact a facility's operations.

CMS additionally seeks comment on approaches to incentivize the advancement of health equity for all SNFs, including the development of new health equity focused measures. We bring

⁴ Carter B and Hado E. Using Data to Disrupt Health Disparities: Lessons Learned from the Coronavirus Pandemic. AARP Blog. November 9, 2020. Available at <https://blog.aarp.org/thinking-policy/using-data-to-disrupt-health-disparities-lessons-learned-from-the-coronavirus-pandemic>.

⁵ Park YJ and Martin EG. Geographic Disparities in Access to Nursing Home Services: Assessing Fiscal Stress and Quality of Care. Health Services Research. 53:2932-2951, 2018.

attention to a systematic assessment of the state of our nation’s nursing homes from the National Academies of Sciences, Engineering, and Medicine (NASEM), which speaks to the challenges that continue to be faced by SNFs and their residents. AARP supports, and recommends for serious consideration by CMS, Recommendation 6D from the Academies’ report that addresses health equity in these facilities, including development of new measures of disparities.⁶ We further encourage CMS to give high priority to measures developed in response to issues identified through review and analysis of resident and caregiver complaints, Quality Improvement Organization (QIO) outreach, ombudsmen investigations, and surveyor reports.

CMS also seeks comment specifically on approaches, such as stratification and risk adjustment, that may be applied in conjunction with potential incentive approaches to advance health equity. AARP believes stratification is a necessary step to both highlight disparities and develop action steps to address it. AARP supports CMS’ use of within-provider and across-provider stratification as both provide important information for health care providers, patients/residents, and their families. The former highlights disparities in individual care among the provider’s patient population and presents an opportunity for internal innovation and quality improvement towards more equitable care. The latter presents provider to provider comparisons, which is helpful benchmarking for health care providers’ improvement efforts and is critical for consumer and family caregiver engagement and informed decision making. We emphasize, however, that reliable stratified results demand consistent collection of standardized data elements, principles for which we have articulated to you in [prior comment letters](#).

In addition, AARP continues to believe that transparency is a significant driver of improvement, effective (as years of public reporting have shown) at changing behavior, and essential in assisting SNF residents and their family caregivers in their informed decision making. To that end, making meaningful progress in reducing disparities should include public reporting of stratified measures. However, we encourage CMS to consider potential unintended negative consequences of reporting stratified measures alongside an overall measure, and any consequent effect on the usefulness of such measures for SNF residents and their caregivers. For instance, if both stratified measures and overall measures are reported, it is important to consider how the measures are presented in public reporting in a meaningful and transparent way such that having two sets of measures does not create confusion among residents and caregivers or lead to cherry-picking in how providers showcase their results. To note, if the overall measure is to be risk-adjusted for social demographic or social risk factors, that may obscure true differences in quality and potentially obviate progress towards greater disparities reporting. In contrast, stratification, which compares quality between the groups to show how similar or different they are, is a simple concept for providers, individuals, and families to understand and can be very helpful in consumer and family decision-making.

Lastly, with respect to the specific request for comment relating to the adoption of quality domains that could incorporate health equity, if domains are established, we encourage CMS to consider a structure that emphasizes successful performance with respect to measures within a domain through the documentation of efforts. Relying solely on attestation to completion of

⁶ National Academies of Sciences, Engineering, and Medicine 2022. The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26526>.

elements of such measures within a domain is not sufficient. Element completion should be documented through auditing. To provide more actionable information for consumers, CMS may also want to consider keeping different measures within a domain as separate scores in terms of information for consumers and their families and not just a composite score for the domain.

Proposal to Update SNF VBP Program Validation Process

AARP continues to support the value of and absolute necessity for a validation process tailored to the expanded SNF VBP Program. This is especially critical as the SNF VBP Program provides clear financial incentives for better performance by facilities (achievement and improvement). We recommend CMS take such steps as are necessary to ensure that beneficiary and family caregiver representatives are consulted during validation process development so that the process results ultimately can be reported publicly in a manner that is meaningful for them. CMS mentions intent for proposing a validation process for the SNF QRP in future rulemaking, and AARP reiterates our recommendation for beneficiary and family caregiver consultation in the development of that process as well.

FY 2024 Proposed Updates to the SNF Payment Rates

In FY 2020, CMS implemented a new case-mix classification system, the Patient Driven Payment Model (PDPM), which is based on clinically relevant factors, including reason for admission. The transition to the PDPM was implemented in a budget neutral manner. However, since the PDPM implementation, CMS' data analysis showed an unintended increase in yearly SNF payments. In the FY 2023, SNF Prospective Payment System (PPS) final rule, CMS finalized a PDPM parity adjustment factor of 4.6% to account for the increase in SNF payments. CMS finalized a two-year phase-in period for this adjustment with a 2.3% reduction in FY 2023 and a 2.3% payment reduction in FY 2024 SNF payment rates.

AARP believes that it is critical for CMS to continue to monitor the impact of the PDPM on beneficiaries' access to appropriate SNF services, including access to therapy services (see also our [prior years' SNF payment rule comment](#) letters on this issue). Ongoing and active monitoring will help enable CMS to address any emerging problems affecting SNF residents, including due to the PDPM parity adjustment.

Civil Money Penalties: Waiver of Hearing, Automatic Reduction of Penalty Amount

CMS proposes to remove the requirement that a facility must submit a written request to waive its right to a hearing and receive a 35 percent reduction in the amount of civil money penalties (CMPs) owed in lieu of contesting the enforcement action. Instead, CMS proposes to substitute a constructive waiver process that would operate by default when a timely request for hearing is not received, and the current 35 percent penalty reduction would continue to apply.

AARP opposes this proposal. While a written request for a waiver may seem to be mere paperwork, it is not. The written request contains an important element of accountability. The filing of a written waiver requires the facility or corporation to take into account that they will be

charged a penalty for improper conduct, and by taking this action they are accepting responsibility for their conduct. AARP is concerned that if facilities are no longer required to proactively request a waiver to receive the reduction, there is no longer any corporate acknowledgement that a wrong has occurred that resulted in the penalty. The reduced penalties become a cost of doing business.

Conclusion

AARP appreciates the opportunity to comment on this proposed rule. We urge CMS to keep the needs of residents and their families front and center as you finalize this rule and make longer-term policy decisions. If you have any questions, please contact me or Rhonda Richards on our Government Affairs staff at r-richards@aarp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a long horizontal flourish extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs