

May 27, 2026

Dr. Mehmet Oz  
Administrator, Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Submitted electronically via: [www.regulations.gov](http://www.regulations.gov)

**RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for FY 2027 (CMS-1843-P)**

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule updating the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for fiscal year (FY) 2027. ANA commends CMS's continued efforts to improve the SNF PPS and associated quality programs. To achieve the agency's stated goals of advancing quality, transparency, and equitable access to care, CMS must ensure that its policies more directly support the nursing workforce and prioritize resident-centered outcomes. This includes aligning payment policy with workforce realities, ensuring Medicare funds are directed toward direct care and nursing staff, addressing wage disparities across settings and geographies, strengthening the use of auditable and meaningful quality measures, and enhancing accountability for data accuracy and resource allocation.

Efforts such as expanded quality reporting, enhanced oversight of case-mix accuracy, and broader data submission requirements are important steps toward ensuring accountability and fostering a more consistent and comparable picture of SNF performance across the healthcare system. At the same time, it is essential that these policies are implemented in a way that fully recognizes the central role of the nursing workforce in driving patient outcomes and quality performance. As CMS advances policies that increase reporting expectations and link payment to quality measures—including a proposed 2.4% payment update and expanded Minimum Data Set (MDS) reporting to all residents regardless of payer—we urge the agency to ensure that payment adequacy, documentation requirements, and quality programs are aligned with the realities of nursing staffing, workload, and clinical care delivery.

Achieving the shared goals of transparency and accountability will depend on sustaining a stable, well-supported nursing workforce and ensuring that measures of quality meaningfully reflect clinical care, coordination, and professional judgment—not solely documentation or reporting

compliance. We encourage CMS to continue advancing oversight and integrity while also prioritizing policies that enable nurses to deliver high-quality, patient-centered care within an increasingly complex regulatory environment.

ANA represents the interests of more than 5 million registered nurses (RNs) through its constituent and state nursing associations, organizational affiliates, and individual members. ANA advances the nursing profession by championing nurses, fostering rigorous standards of nursing practice, promoting safe and ethical work environments, supporting nurses' health and wellness, and advocating health care issues that affect both nurses and their patients. ANA's membership includes RNs and Advanced Practice Registered Nurses (APRNs)—nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs)—who practice across the care continuum, including in skilled nursing and long-term care settings.

Nursing is a profession grounded in critical thinking, scientific rigor, and evidence-based practice. Nurses are central to the delivery of high-quality, resident-centered care in SNFs and serve in essential direct care, care coordination, research, and administrative leadership roles. Nurses form the backbone of the American health care system, providing and coordinating care, educating patients and the public, and offering counsel and emotional support to patients and their families. As the most trusted profession, nurses play a critical role in influencing health outcomes.<sup>1</sup>

**Accordingly, ANA urges CMS to ensure that policies finalized in this rule support a sustainable nursing workforce, promote safe staffing, advance meaningful quality improvement, and fully reflect nursing contributions.**

#### **1. CMS must Align SNF Payment Accountability and Transparency Policies to Ensure Investment in the Nursing Workforce and Direct Patient Care.**

ANA supports CMS's goals of improving quality, advancing transparency, and better aligning post-acute care across settings.<sup>2</sup> However, payment and quality policies must not unintentionally undermine these goals by exacerbating nursing workforce across settings.

**ANA has long advocated for the following pillars of workforce sustainability, and we urge CMS to implement initiatives that advance these goals:**

- wage parity for nurses performing comparable work across all care settings;
- workforce investments that support recruitment, retention, and safe staffing;

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<sup>1</sup> Brenan, M. (2026, January 12). Nurses continue to lead in honesty and ethics ratings. Gallup. <https://news.gallup.com/poll/700736/nurses-continue-lead-honesty-ethics-ratings.aspx>

<sup>2</sup> Centers for Medicare & Medicaid Services. (2025, December 1). *Quarterly nursing home provider data for U.S. and California*. <https://data.cms.gov/provider-data/dataset/4pq5-n9py>

- accountability to ensure health care payments are directed toward patient care and the nursing workforce; and
- policies that recognize nursing as essential to quality, safety, and care continuity.

SNF payment levels directly influence RN staffing levels, wage competitiveness, and investments in training and retention. Current Medicare payment policies for SNFs are misaligned with these principles, as evidenced by Medicare cost reports that show a high proportion of SNF revenues are spent on administration and profits rather than direct patient care.<sup>3</sup> By reimbursing SNFs using hospital wage assumptions and without requiring pass-through of those funds to nursing staff, CMS contributes to wage inequity, workforce instability, and persistent nursing shortages—particularly in long-term and post-acute care settings.

CMS understands that SNFs frequently fail to use PPS to sufficiently provide staff facilities or provide needed services. By limiting administrative costs, capital expenditures, and profit levels that are not aligned with patient care investments, facilities could reallocate revenues toward nursing, ancillary, and support services.<sup>4,5</sup> The Government Accountability Office (GAO) recommended that CMS take steps to ensure that cost data are reliable and made readily accessible to public stakeholders.<sup>6</sup>

**As such, ANA urges CMS to establish clear, enforceable requirements to ensure that Medicare SNF payments are primarily directed toward resident care and support the nursing workforce, including by promoting wage parity for nurses performing comparable work across care settings.** This should include greater transparency and accountability mechanisms to ensure that payment increases are appropriately passed through to direct care staff and invested in staffing, retention, and patient care delivery.

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<sup>3</sup> U.S. Government Accountability Office. (2016, September). *Skilled nursing facilities: CMS should improve accessibility and reliability of expenditure data* (GAO-16-700). <https://www.gao.gov/products/GAO-16-700>

<sup>4</sup> Harrington, C., Mollot, R., Braun, R. T., & Williams, D., Jr. (2024). United States' nursing home finances: Spending, profitability, and capital structure. *International Journal of Social Determinants of Health and Health Services*, 54(2), 131–142. <https://doi.org/10.1177/27551938231221509>

<sup>5</sup> U.S. Government Accountability Office. (2016, September). *Skilled nursing facilities: CMS should improve accessibility and reliability of expenditure data* (GAO-16-700). U.S. Government Accountability Office. <https://www.gao.gov/products/GAO-16-700>

<sup>6</sup> Ibid.

## **2. Eliminate Rural Nursing Payment Disparities to Advance Wage Parity and Ensure Equitable Access to Care.**

The proposed federal wage per diem rates for FY 2027 continue to disadvantage rural SNFs. Under the current approach, nursing services are reimbursed at lower rates in rural facilities than in urban facilities (see tables 3, 4, 5 and B5). This means that rural facilities receive lower Medicare payments, specifically for nursing care. These payment differences matter not only because they directly affect a facility's ability to hire and retain nurses, but they also directly reduce rural SNFs' ability to recruit and retain nurses and worsen already significant workforce challenges. As such, **ANA strongly urges CMS to eliminate nursing wage adjustments that disadvantage rural facilities and to adopt payment policies that reflect workforce realities and resident care needs regardless of geography.**

National workforce projections indicate that nursing shortages will persist for many years, with rural areas facing more severe deficits.<sup>7, 8</sup> Payment policies that undervalue nursing care in rural settings make it more difficult for facilities to compete for nurses and maintain safe staffing levels—an **approach fundamentally misaligned with the Administration's goals to improve rural access to care.**

When CMS repealed its Minimum Staffing Regulation, which ANA strongly opposed, it listed nursing shortages as one of the reasons for the repeal.<sup>9,10,11</sup> But, every year more than 100,000 nurses leave the workforce due to stress, burnout, and unsafe work environments. Claims that minimum staffing standards cannot be met due to a shortage of nurses ignore the reality that

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<sup>7</sup> Towsley, G. L., Beck, S. L., Dudley, W. N., & Pepper, G. A. (2011). Staffing levels in rural SNFs. *Journal of Gerontological Nursing*, 37(4), 1–14. [https://libres.uncg.edu/ir/uncg/f/W\\_Dudley\\_Staffing\\_2011.pdf](https://libres.uncg.edu/ir/uncg/f/W_Dudley_Staffing_2011.pdf)

<sup>8</sup> American Association of Colleges of Nursing. (2024). *Nursing shortages fact sheet*. <https://www.aacnnursing.org/news-data/fact-sheets/nursing-shortage>.

<sup>9</sup> American Nurses Association. (2026, January 27). *Comment letter on long term care (LTC) rule repeal*. <https://www.nursingworld.org/globalassets/docs/ana/comment-letters/2026.01.27-ltc-rule-repeal-letter-final.pdf>

<sup>10</sup> Centers for Medicare & Medicaid Services. (2025, December 5). *Medicare and Medicaid programs; Repeal of minimum staffing standards for long-term care facilities*. Federal Register. <https://www.federalregister.gov/documents/2025/12/03/2025-21792/medicare-and-medicaid-programs-repeal-of-minimum-staffing-standards-for-long-term-care-facilities>

<sup>11</sup> U.S. Government Publishing Office. (2025, December 3). *Medicare program; FY 2027 hospice wage index and payment rate update and hospice quality reporting program requirements*. Federal Register. <https://www.govinfo.gov/content/pkg/FR-2025-12-03/pdf/2025-21792.pdf>

unsafe and inadequate working conditions and low pay, not workforce supply—are the primary drivers of nurse attrition in SNF settings.<sup>12,13,14,15,16,17</sup>

Since PPS was implemented for SNFs, CMS has used the hospital inpatient wage data to develop a SNF wage index. This CMS decision to use hospital wages for the rate calculations results in overpayments to SNFs. CMS’s rationale is that there is no specific SNF-wage index. Contrary to the CMS claim of not having a SNF wage index, all SNFs are required to submit Medicare cost reports annually which provide detailed data on wages and benefits for different categories of SNF workers. These data show that actual SNF paid wages are lower than hospital wage rates. **ANA strongly urges CMS to use the Medicare cost reports to develop a SNF-wage index and accurately reflect payments for nursing care and any increase in rates must be tied to funds for staff wages.**

### **3. CMS must reform wage index methodology for SNFs and require wage pass-through policies to achieve nursing wage parity that supports safe, high-quality care.**

CMS is proposing continued use of the current hospital wage index as the base for SNF wage index. Sustainable staffing depends on parity between reimbursement and compensation. Shortages of RNs and nursing staff are caused, in part, because the wages and benefits are lower in SNFs than for hospital nursing staff. In addition, SNFs often have poor working conditions with too many residents to care for. Patients who are transferred from an acute hospital to a SNF for complex care needs should receive the same skills and competencies from nursing staff in SNFs as in hospitals. There should therefore be no wage differential between these two settings. ANA urges CMS to formally incorporate wage parity expectations into the SNF PPS.

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<sup>12</sup> Centers for Medicare & Medicaid Services. (2023, June). *Nursing home staffing study: Comprehensive report (Appendix)*. <https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

<sup>13</sup> National Council of State Boards of Nursing. (2024). *NCSBN research highlights small steps toward nursing workforce recovery; burnout and staffing challenges persist*. [NCSBN Research Highlights Small Steps Toward Nursing Workforce Recovery; Burnout and Staffing Challenges Persist | NCSBN](https://www.ncsbn.org/Research/Research-Highlights/Small-Steps-Toward-Nursing-Workforce-Recovery-Burnout-and-Staffing-Challenges-Persist)

<sup>14</sup> Cho, E., Min, D., Heo, S. J., Lee, K., & Kim, H. (2023). Effects of registered nurses’ staffing levels, work environment, and education levels on nursing home residents’ quality of life and nurse outcomes. *Journal of Clinical Nursing*, 32(17–18), 6494–6503. <https://doi.org/10.1111/jocn.16689>

<sup>15</sup> White, E. M., Aiken, L. H., & McHugh, M. D. (2019). Registered nurse burnout, job dissatisfaction, and missed care in nursing homes. *Journal of the American Geriatrics Society*, 67(10), 2065–2071. <https://doi.org/10.1111/jgs.16051>

<sup>16</sup> Centers for Medicare & Medicaid Services. (n.d.). *Provider information* [Data set]. Data.CMS.gov. <https://data.cms.gov/provider-data/dataset/4pg5-n9py>

<sup>17</sup> PHI. (2022, August). *Direct care workers in the United States: Key facts*. <https://www.phinational.org/wp-content/uploads/2022/08/DCW-in-the-United-States-2022-PHI.pdf>

Lower wages are a primary driver of RN shortages and staff moving into other occupations from SNFs settings, particularly given demanding working conditions and high resident acuity.<sup>18</sup> SNFs compete directly with hospitals for the same nursing workforce, yet hospital-based RNs earn significantly more. Federal labor data confirm this disparity: in 2024, hospital-based RNs earned a median annual wage of \$97,260 compared with \$81,820 for SNF-based RNs.<sup>19</sup>

Sustainable staffing depends on parity between reimbursement and compensation. Shortages of RNs and nursing staff are caused, in part, because the wages and benefits are lower in SNFs than for hospital nursing staff. In addition, SNFs often have poor working conditions with too many residents to care for. Patients who are transferred from an acute hospital to a SNF for complex care needs should receive the same skills and competencies from nursing staff in SNFs as in hospitals. There should therefore be no wage differential between these two settings. ANA urges CMS to formally incorporate wage parity expectations into the SNF PPS.

Despite this gap, CMS bases the SNF wage index on hospital wage data, assuming SNFs pay hospital-level wages without requiring facilities to pass those funds through to nurses. Medicare funds intended to support nursing care therefore do not consistently reach the nursing workforce, undermining workforce stability and quality.

CMS must not rely on hospital wage data based on the absence of audited skilled nursing facility (SNF) cost reports. While ANA agrees that unaudited cost report data are often inaccurate, CMS has clear authority to require SNFs to submit fully audited Medicare cost reports prepared by an independent certified public accountant as a condition of participation. SNFs already report detailed wage and benefit information by staff category, and CMS has the tools necessary to ensure accountability for how Medicare funds are used. **CMS should require that SNF reimbursement be based on audited, facility-specific wage data or, alternatively, implement enforceable wage pass-through requirements tied to payment.** CMS is paying for nursing care and should ensure that these funds are used to support the delivery of nursing services, rather than diverted to profit or non-essential expenditures. If CMS continues to rely on hospital wage indices, it should condition SNF payment on facilities demonstrating that nursing staff wages are comparable to hospital levels to promote workforce equity, ensure accountability for federal funds, and support safe, high-quality, resident-centered care.

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<sup>18</sup> PHI International. (2025). *Direct care workers in the United States: Key facts*. PHI. <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2025/>

<sup>19</sup> U.S. Bureau of Labor Statistics. (2024, May). *National industry-specific occupational employment and wage estimates (NAICS 623000)*. [https://www.bls.gov/oes/current/naics3\\_623000.htm](https://www.bls.gov/oes/current/naics3_623000.htm)

#### 4. **Prioritize Auditable Quality Measures and Strengthen Data Integrity Requirements for Self-Reported Reporting in the SNF Quality Reporting Program (QRP).**

##### **a. General Considerations**

The Minimum Data Set (MDS) serves as a standardized set of screening, clinical, and functional status elements that form the basis of the comprehensive assessment required for all residents in Medicare- or Medicaid-certified nursing facilities, consistent with section 1888(e)(4)(G)(i) of the Social Security Act. These data are used for both payment determinations and quality monitoring.

**Because MDS data are self-reported by facilities, ANA is concerned about the completeness, accuracy, and reliability of these data for these critical purposes.**

ANA urges CMS to discontinue reliance on self-reported MDS based quality measures due to longstanding concerns regarding data accuracy and completeness. Many quality problems are under-reported because of the underfunding of state agencies and the short staffing.<sup>20,21</sup> **ANA strongly supports the use of claims-based measures and auditable structural measures, including the Payroll Based Journey (PBJ) data capturing staffing hours and turnover for RNs, licensed practical nurses (LPNs), and certified nursing assistants (CNAs).**

**ANA further urges CMS to prioritize auditable input and structural measures as core quality indicators.** Measure-based PBJ data, total staffing hours, and staff turnover all provide concrete, reviewable information directly linked to care quality and resident outcomes. **If CMS continues to rely on self-reported data, it must implement robust auditing, verification, and penalty systems to ensure data integrity and accountability.**

##### **b. CMS Should Not Remove COVID-19 Vaccination Reporting Measures.**

CMS proposes updates to the SNF QRP including removing two measures from the program, specifically the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure and the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure. While ANA has supported removing COVID-19 vaccination reporting requirements in other settings, **ANA does not support eliminating COVID-19 vaccination reporting measures within the SNF QRP for health care personnel or residents.** SNFs are congregate care settings serving medically complex

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<sup>20</sup> U.S. Senate Special Committee on Aging. (2023, May). *Uninspected and neglected: Nursing home inspection agencies are severely understaffed, putting residents at risk.* [UNINSPECTED & NEGLECTED - FINAL REPORT.pdf](#)

<sup>21</sup> Office of Inspector General. (2019, April). *Trends in deficiencies at nursing homes show that improvements are needed to ensure the health and safety of residents* (HHS Data Brief No. 09-18-02010). U.S. Department of Health and Human Services. [Trends in Deficiencies at Nursing Homes Show That Improvements Are Needed To Ensure the Health and Safety of Residents | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services](#)

residents. The COVID-19 pandemic had a devastating impact on nursing home residents, with hundreds of thousands of deaths in long-term care settings and a disproportionate burden of mortality in the early waves. Continued reporting and oversight are critical to safeguard this vulnerable population and to ensure readiness for future infectious disease threats. <sup>22,23</sup>

Continued infectious disease reporting—including vaccination coverage—remains essential for SNFs given ongoing outbreaks of other communicable diseases, such as measles. Reliance on self-reported data alone is insufficient. **CMS should strengthen oversight by enhancing auditing and verification systems, while also providing targeted resources and technical assistance to support accurate reporting. The agency should consider appropriate accountability mechanisms to address persistent underreporting or data inaccuracies.**

**c. Expanded Minimum Data Set (MDS) Reporting (All Skilled Residents Regardless of Payer).**

CMS is proposing to require the submission of MDS data on each resident receiving covered skilled care in a SNF, regardless of payer. **ANA strongly supports requiring MDS submission for all SNF residents and urges CMS to implement this requirement no later than FY 2028.** Most facilities already collect this data, and timely implementation is essential for accurate acuity assessment and care planning.

**5. Expand Payroll Based Journal (PBJ) Data Oversight and Establish Standards for Interdisciplinary Staffing to Improve Care Quality in the SNF Value-Based Purchasing (SNF VBP) Program.**

**ANA supports CMS's current VBP measures related to 30-day all-cause readmissions, infections, staffing hours, turnover, and hospitalizations.** ANA also supports the use of PBJ data and urges CMS to strengthen oversight by reviewing and auditing these data more frequently. CMS should focus on existing structural information within PBJ data, including reported hours for medical directors, social workers, pharmacists, therapists, dietitians, and activities staff. These professionals are essential to meeting residents' complex needs; yet PBJ data suggest that many facilities fail to provide required professional services or report implausible staffing patterns. ANA

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<sup>22</sup> Centers for Disease Control and Prevention. (2020b). COVID-19 in a long-term care facility—King County, Washington, February 27–March 9, 2020. *Morbidity and Mortality Weekly Report*, 69(12), 339–342. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm>

<sup>23</sup> Chidambaram, P. (2022, February 3). *Over 200,000 residents and staff in long-term care facilities have died from COVID-19.* KFF. <https://www.kff.org/covid-19/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/>

also urges CMS to strengthen PBJ auditing and to establish enforceable standards for professional service hours per resident day to ensure residents receive comprehensive interdisciplinary care.

## 6. Requests for Information

CMS is seeking feedback on one potential measure topic for the SNF QRP—advanced care planning—and on potential updates to the Patient Driven Payment Model (PDPM) payment system as part of a broader effort to ensure that payment policy reflects current care practices and changes in the SNF resident population. The RFI also focuses on how CMS could address observed Case Mix Upcoding. ANA urges the agency to ensure nurses are included in the development of these potential measures.

### a. CMS Should Advance Quality Measures on Advanced Care Planning (ACP)

CMS is seeking input on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advanced care planning. **ANA strongly supports CMS's interest in advancing high-quality, resident- and patient-centered ACP directives through future quality measurement.** Nurses already play a central and indispensable role in ACP across care settings, including SNFs. This work includes engaging patients and families in ongoing conversations about care goals and preferences; ensuring patients are informed of their rights; documenting and updating advance directives; coordinating with physicians and specialty providers; connecting patients to home- and community-based supports following discharge; and ensuring that patients' decisions are understood, honored, and respected throughout the course of care. Any ACP quality measures for SNFs must therefore reflect and capture the substantive conversations, coordination activities, and clinical judgment that nurses and other health care professionals routinely provide as part of this process.

**ANA urges CMS to prioritize ACP quality measures that are auditable, clinically meaningful, and derived from reliable data sources, including electronic health records and claims-based data, rather than self-reported or checkbox-based measures.** The National Quality Forum (NQF) has endorsed ACP as a core quality measure (NQF #0326), underscoring its importance in patient-centered care for individuals with advanced illness.<sup>24</sup> Examples of meaningful ACP measures include the timely identification and engagement of surrogate decision-makers; documentation of goals-of-care discussions with patients and their surrogates; and evidence of alignment between a patient's documented preferences and the treatments ultimately provided. These measures would more accurately reflect the intent and quality of ACP than form completion alone.

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<sup>24</sup> Centers for Medicare & Medicaid Services. (2020). *2020 measure 047 MIPS clinical quality measure (CQM) specification*. [https://qpp.cms.gov/docs/QPP\\_quality\\_measure\\_specifications/CQM-Measures/2020\\_Measure\\_047\\_MIPSCQM.pdf](https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_047_MIPSCQM.pdf)

However, ANA emphasizes that successful implementation of ACP measures depends on adequate workforce support. Before adopting new ACP quality measures, CMS must ensure that nurses and other clinical staff have sufficient time, staffing, resources, training, and education to engage in high-quality ACP conversations and to document these discussions accurately and comprehensively. Without these supports, ACP requirements risk becoming additional administrative burdens rather than tools to improve care quality and patient outcomes.

**As such, ANA urges CMS to meaningfully include nurses in the development and refinement of ACP quality measures and to adopt measures that reflect real-world clinical workflows, interdisciplinary care, and the critical role nurses play in advance care planning.** ACP measurement should reinforce person-centered care, reduce decisional burden for patients and families, and support—rather than hinder—the clinical practice of nurses who are integral to ACP.

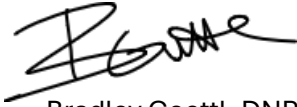
**b. CMS Should Aligning SNF Nurse Staffing Payments with Resident Care Needs Under Payment Model Case-Mix Methodology (PDPM).**

The PDPM is a case-mix classification system used by Medicare for Skilled Nursing Facility (SNF) Prospective Payment System (PPS) reimbursement. CMS is seeking information on the methodology for quantifying and addressing case-mix creep under PDPM. The CMS Medicare rate for the nursing component of the base-rate is based on the typical SNF staffing levels, rather than on what the staffing levels should be for each SNF's average resident case-mix. **ANA urges CMS to base nurse staffing payment rates on the level of nursing care required for residents under each PDPM nursing case-mix category, rather than on current or typical facility staffing patterns.** CMS should develop and issue clear guidance that links expected nurse staffing levels to PDPM nursing case-mix indices (CMIs), providing facilities with a transparent and standardized framework to determine appropriate staffing. CMS should also establish accountability mechanisms to ensure SNFs maintain staffing levels that are aligned with resident acuity and support the delivery of safe, high-quality care.

Additionally, **ANA urges CMS to address persistent case-mix creep under PDPM by strengthening audits, enforcing accountability, and restoring required resident assessments at days 14, 30, 60, and 90, to improve the accuracy of the PDPM assessments as well as the accuracy of Quality Measures that are based on MDS data.** Without these actions, CMS cannot ensure payment accuracy, protect residents, nor safeguard federal funds.

ANA appreciates the opportunity to have this discussion and looks forward to continued engagement with CMS on shared priorities. Please contact Tim Nanof, ANA's Executive Vice President, Policy & Government Affairs at (301) 628-5166 or [tim.nanof@ana.org](mailto:tim.nanof@ana.org) with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'B. Goettl', written in a cursive style.

Bradley Goettl, DNP, DHA, RN, FAAN, FACHE  
Chief Nursing Officer

cc: Jennifer Mensik Kennedy, PhD, RN, NEA-BC, FAAN, ANA President  
Angela Beddoe, ANA Chief Executive Officer