June 24, 2019

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1716-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically to www.regulations.gov

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals [CMS-1716-P | RIN 0938-AT73]

Dear Administrator Verma:

The American Nurses Association (ANA) is pleased to comment on the Centers for Medicare & Medicaid Services (CMS) Fiscal Year 2020 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System proposed rule. Through this comment letter, we urge CMS to:

- Recognize the importance of appropriate nurse staffing levels by recognition of two NQF-endorsed staffing measures - NQF #0204 – Nurse Skill Mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract) and NQF #0205 – Nurse Hours per Patient Day – in the Hospital Inpatient Quality Reporting (IQR) Program for public reporting;
- Require inpatient hospitals that participate in the Medicare program to implement meaningful programs that prevent workplace violence;
- Include the Safe Use of Opioids – Concurrent Prescribing eCQM measure in the Hospital IQR Program eCQM measure set.

ANA is the premier organization representing the interests of the nation's 4.0 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family

members. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).[1] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

I) ANA Urges CMS to Include Two Nurse Staffing Measures in the Hospital Inpatient Quality Reporting Program for Public Reporting (Section VIII.A.8. Potential Future Quality Measures)

In *Section VIII.A.8. Potential Future Quality Measures*, CMS invites public comment on its proposal to consider a *Hospital Harm – Severe Hypoglycemia eCQM*, a *Hospital Harm – Pressure Injury eCQM*, and a *Cesarean Birth eCQM* for future inclusion in the Hospital IQR Program and/or the Promoting Interoperability Program for public reporting. CMS notes in this section that it is guided in these proposals by the framework of the Meaningful Measures Initiative.

ANA strongly believes that CMS should also consider for future inclusion in the Hospital IQR Program two National Quality Forum (NQF)-endorsed nurse staffing measures: NQF #0204 – Nurse Skill Mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract) and NQF #0205 – Nurse Hours per Patient Day. These measures contribute to the Meaningful Measures Initiative's stated objectives, contribute significantly to improved patient outcomes, empower patients and their families and caregivers, increase transparency with respect to care decisions, and do not represent an additional or significant reporting burden for providers. Both measures are currently under review by the NQF Patient Safety Committee and are expected to receive re-endorsement.

These nurse staffing measures achieve several of CMS' stated objectives under the Meaningful Measures Initiative. ANA's nurse staffing measures address high-impact measure areas that safeguard public health and are patient-centered and meaningful to patients. Nurse staffing plays an important role by ensuring that the nurse is provided adequate time and resources to prepare each patient for discharge. Robust levels of nurse staffing hold promise for preventing unnecessary hospital readmissions for all patients through more effective pre-discharge monitoring of patient conditions and improved discharge preparation:[2]

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[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

[2] Tubbs-Cooley, H.L., Cimiotti, J.P., Silber, J.H., Sloane, D.M., Aiken, L.H. (2013). An observational study of nurse staffing ratios and hospital readmission among children admitted for common conditions. *BMJ Quality & Safety, 22*(9): 735-42. doi: 10.1136/bmjqs-2012-001610.

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- Each additional patient added to a nurse's average case load increases odds of 30-day readmission 6-9% due to poor nurse working environment and staffing.[3] Conversely, patients who receive care in "better" nurse work environments have lower odds of readmission.[4]

- Hospitals staffed with 8 RN hours per adjusted patient day have 25% lower odds of receiving readmissions penalties when compared to similar hospitals staffed with 5.1 RN hours per adjusted patient day.[5]

- Missed standard nursing care activities during a patient's hospitalization, such as educating patients and their families, care-coordination, care planning, and treatments, are associated with increased odds of readmission of 2-8%, after adjusting for patient and hospital characteristics. This suggests that providing nurses with sufficient time and resources to address various patient needs can help reduce readmission rates.[6]

- Higher RN non-overtime staffing decreased the odds of readmission of medical/surgical patients by 50% and reduces post-discharge emergency department visits. Hospitals could potentially reduce post-discharge utilization costs and readmissions by increasing investment in nursing care hours to better prepare patients to manage their care at home prior to discharge.[7]

ANA notes that with respect to reporting burden, approximately half of all inpatient hospitals in the nation already collect and report these measures voluntarily, pointing not only to their value but also to the lack of burden for providers to do so. According to the 2018 National Database of Nursing Quality Indicators (NDNQI) site coordinator survey – conducted as part of the NQF Spring 2019 re-endorsement process for both measures – the average total time per month it takes to extract, clean, and submit data related to the staffing measures is 6 hours. Almost half of all respondents indicated that it takes fewer than two hours per month to extract the data for each of the NQF #0204 (45.8%) and NQF #0205 (44.2%) measures, while almost half of all respondents also indicated that it takes fewer than two hours per month to clean and process the data for each of the NQF #0204 (46.5%) and NQF #0205 (45.1%) measures. Collecting and reporting data on these important nurse staffing measures is not unduly burdensome.

Furthermore, ANA included a sub-measure of each NQF #0204 and NQF #0205 as part of the Spring 2019 NQF re-endorsement process that measures only Medical, Surgical, and Medical-Surgical units. The

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[3] McHugh, M.D., Ma, C. (2013). Hospital Nursing and 30-Day Readmissions among Medicare Patients with Heart Failure, Acute Myocardial Infarction, and Pneumonia. *Medical Care, 51*(1): 52-59. doi: 10.1097/MLR.0b013e3182763284.

[4] Ma, C., McHugh, M.D., Aiken, L.H. (2015). Organization of Hospital Nursing and 30-Day Readmissions in Medicare Patients Undergoing Surgery. *Medical Care, 53*(1): 65-70. doi: 10.1097/MLR.0000000000000258.

[5] McHugh, M.D., Berez, J., Small, D.S. (2013). Hospitals with higher nurse staffing had lower odds of readmissions penalties than hospitals with lower staffing. *Health Affairs (Millwood), 32*(10): 1740-7. doi: 10.1377/hlthaff.2013.0613.

[6] Carthon, J.M., Lasater, K.B., Sloane, D.M., Kutney-Lee, A. (2015). The quality of hospital work environments and missed nursing care is linked to heart failure readmissions: a cross-sectional study of US hospitals. *BMJ Quality & Safety, 24*(4): 255-63. doi: 10.1136/bmjqs-2014-003346.

[7] Weiss, M.E., Yakusheva, O., Bobay, K.L. (2011). Quality and cost analysis of nurse staffing, discharge preparation, and postdischarge utilization. *Health Services Research Journal, 46*(5): 1473-94. doi: 10.1111/j.1475-6773.2011.01267.x.

data for these sub-measures represent even less of an already minimal reporting burden to collect, clean, and report, and ANA hopes to further engage with CMS on these specific sub-measures.

These measures would provide enormous benefits through better data collection, while imposing minimal additional costs. As detailed above, adequate nurse staffing in hospitals has a significant positive impact on reducing patient readmissions. Such readmissions can be avoidable – and very costly. The June 2013 Medicare Payment Advisory Commission (MedPAC) Report to the Congress estimated that reducing avoidable readmissions by even 10% would save Medicare $1 billion.[8] Given the impact that nurse staffing has on reducing such avoidable readmissions, including these measures for public reporting in the Hospital IQR Program represents a clear financial benefit to the Medicare program.

CMS itself clearly recognizes that the role of the RN – and subsequently nurse staffing patterns – is critical to patient care and outcomes. As CMS noted in its comments in the FY 2018 IPPS/LTCH PPS final rule, numerous studies have clearly and consistently shown a link between appropriate nurse staffing and care quality and patient outcomes. Increased nurse staffing is demonstrably associated with a reduction in hospital-related mortality and adverse patient events, such as respiratory failure, cardiac arrest, and hospital-acquired infections. Studies have also found that increased nurse staffing is associated with reduced patient length of stay, reduced rate of readmissions, and reduced hospital costs. CMS also acknowledges that over 2,000 inpatient hospitals currently report this data.

ANA looks forward to engaging with CMS to ensure that the value of nursing in patient care is transparent and available to patients, their families and caregivers when considering hospital care and emphasize the immense value and minimal burden represented in reporting these measures.

II) ANA Requests to Collaborate with CMS to Require Inpatient Hospitals that Participate in Medicare to Implement Meaningful Programs to Prevent Workplace Violence

ANA believes that the proposed rule misses an important opportunity to hold hospitals accountable for steps to prevent incidents of violence, particularly violence against health care practitioners on hospital premises. The Government Accountability Office (GAO) has reported that rates of workplace violence in health care settings are 5 to 12 times higher than the estimated rates for workers overall.[9] This is a critical issue from ANA's perspective, given that RNs are often the front line providers in hospitals and other settings.[10] Workplace violence has a demonstrable negative impact, including adverse effects on patient outcomes.[11]

[8] Medicare Payment Advisory Commission. (2013). Report to the Congress: Medicare and the Health Care Delivery System. 96. http://www.medpac.gov/docs/default-source/reports/jun13_ch04.pdf.

[9] U.S. Government Accountability Office. Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. 2016. Accessible at https://www.gao.gov/products/GAO-16-11.

[10] American Nurses Association. Position Statement on Incivility, Bullying, and Workplace Violence. 2015. Accessible at https://www.nursingworld.org/practice-policy/work-environment/violence-incivility-bullying/

[11] Roche, M. et al. Violence Toward Nurses, the Work Environment, and Patient Outcomes. Journal of Nursing Scholarship. 2010.

The Occupational Safety and Health Administration (OSHA) has published guidelines that are a blueprint for action by providers, including hospitals.[12] ANA supports interagency and legislative strategies to develop and apply enforceable standards across the health care system, based on these guidelines. However, CMS currently has the authority and necessary tools to ensure that hospitals take appropriate action to reduce violence in hospital settings.

As a first step, hospitals reimbursed by Medicare should be held accountable for having violence prevention programs. As the guidelines suggest, components of an appropriate program would include: 1) Active participation of nurses and other staff in violence prevention; 2) Systems to document incidents of workplace violence; 3) Risk assessment; 4) On-site training on prevention; and 5) Regular evaluation of program effectiveness.

As a purchaser of hospital services, CMS has a unique role and obligation to engage hospitals in violence prevention, consistent with improving clinical quality and experience of care in Medicare. ANA urges CMS in the final rule, at a minimum, to require hospitals to have meaningful programs to prevent workplace violence. Moreover, we would be pleased to assist CMS on an ongoing basis to build out a comprehensive response to workplace violence, which has a profound impact on our members as well as Medicare and Medicaid patients.

III) ANA Supports the Inclusion of the Safe Use of Opioids – Concurrent Prescribing eCQM in the Hospital Inpatient Quality Reporting Program eCQM Measure Set (Section VIII.A.5.a. Adoption of Two Opioid-Related eCQMs)

In *Section VIII.A.5.a. Proposed Adoption of Two Opioid-Related eCQMs*, CMS proposes to include the Safe Use of Opioids – Concurrent Prescribing eCQM, and the Hospital Harm - Opioid-Related Adverse Events eCQM, to the Hospital Inpatient Quality Reporting (IQR) Program eCQM measure set beginning with the CY 2021 reporting period/FY 2023 payment determination.

ANA supports the inclusion of the Safe Use of Opioids – Concurrent Prescribing eCQM measure in the Hospital IQR Program eCQM measure set. As CMS notes in the proposed rule, fatalities from unintentional opioid overdose have reached epidemic levels in the last 20 years. Forty percent of the 42,000 opioid overdose-related deaths in 2016 involved a prescription opioid, while concurrent use of benzodiazepines with opioids was present in more than thirty percent of fatal overdoses. While the overall number of opioid prescriptions are down, concurrent prescribing of benzodiazepines and opioids presents a significant public health risk.

ANA appreciates CMS' acknowledgment that it is appropriate in some instances to concurrently prescribe opioids and benzodiazepines and that the objective of public reporting is not to reduce the value of this eCQM to zero. As ANA noted in our comments on the HHS Pain Management Best Practices

[12] U.S. Department of Labor, Occupational Safety and Health Administration, Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. 2016. Accessible at https://www.osha.gov/Publications/osha3148.pdf.

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Inter-Agency Task Force Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations:

> Nursing is guided by the *Code of Ethics for Nurses* (the Code), which recognizes stigma and bias in the healthcare setting and in providing care. Provision 1.2 of the Code states "nurses establish relationships of trust and provide nursing services according to need, setting aside any bias or prejudice."[13] Nurses see firsthand how stigma and bias affect patients from receiving proper care. The Code dictates how to use proper treatment methods for patients, not whether a patient receives evidence-based treatment. […] ANA firmly believes that providers should not be penalized for prescribing opioids, or any pain treatment, at the appropriate amount and that patients should not be fearful of following evidence-based treatment plans. Provider-patient relationships are fundamental to quality cost-effective care and setting any limitation on evidence-based care could undermine the relationship.

ANA recognizes the inherent risks associated with concurrent prescription of opioids and benzodiazepines but emphasizes that care decisions ultimately rest on the provider-patient relationship in coordination with the clinical best-practices based on diagnosis.

IV) Conclusion

We look forward to engaging with CMS staff on the issues outlined in this comment letter. If you have any questions, please contact Ingrida Lusis, Vice-President, Policy & Government Affairs, at ingrid.lusis@ana.org or (301) 628-5081.

Sincerely,

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ANA Chief Nursing Officer/EVP

cc: Ernest Grant, PhD, RN, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FACHE, ANA Chief Executive Officer

[13] American Nurses Association (2015, Jan.). Code of Ethics for Nurses with Interpretive Statements. Provision 1.2. Retrieved from https://www.nursingworld.org/coe-view-only