July 1, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals. [CMS-1735-P]

Dear Administrator Verma:

The American Nurses Association (ANA) is pleased to comment on the Centers for Medicare & Medicaid Services (CMS) Fiscal Year 2021 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System proposed rule. Through this comment letter, we urge CMS to:

1. 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;
2. Support the proposed changes and clarifications to the Medicare and Medicaid Promoting Interoperability Programs including to maintain the Electronic Prescribing Objective's Query of the Prescription Drug Monitoring Program (PDMP) measure as optional and worth 5 bonus points and to being publicly reporting electronic clinical quality measures (eCQM) performance data beginning with the eCQM data reported by eligible hospitals and CAHs for the reporting period in CY 2021 on the Hospital Compare and/or data.medicare.gov websites or successor websites;
3. Support continued inclusion of these patient safety measures in the PCH Quality Reporting Program because patient safety measures such as CAUTI and CLABSI are directly tied to nursing excellence in a facility.

ANA is the premier organization representing the interests of the nation's 4 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and the 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 administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health

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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). ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.[1]

1. ***ANA Urges CMS to Include Two Nurse Staffing Measures in the Hospital Inpatient Quality Reporting Program for Public Reporting***

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. NQF re-endorsed both measures in 2019.

These nurse staffing measures contribute to 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]

- 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

[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified 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.

[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.

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 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 2019 re-endorsement process that measures only Medical, Surgical, and Medical-Surgical units. The 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

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[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.

[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.

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.

2. ***ANA supports the proposed changes and clarifications to the Medicare and Medicaid Promoting Interoperability Programs***

CMS is proposing to continue the Query of the PDMP measure as an optional measure worth five bonus points in CY 2021. CMS is also proposing to publicly report eCQM performance data for the first time, beginning with data reported for the CY 2021 reporting period, on Hospital Compare and/or data.edicare.gov, or any successor websites.

Many of our APRN members can prescribe controlled substances and are encouraged, if not mandated, to query the PDMP prior to writing a prescription. While APRNs could fill the provider gaps in rural communities, it is less common for hospitals to hire APRNs. While this proposed rule will affect many other clinician groups to a greater extent than APRNs, ANA supports continuing the query of the PDMP measure as an optional measure worth five bonus points in CY 2021. The Centers for Disease Control and Prevention (CDC) states that PDMPs continue to be among the most promising state-level interventions to improve opioid prescribing, inform clinical practice, and protect patients at risk.[9] As the United States still grapples with the opioid epidemic, a public health emergency since 2017, all programs that can inform clinical practices and therefore help curb the epidemic must continue to be in place. For PDMPs to be an effective tool, providers must input information in "real-time" and information must be interoperable across facilities and systems.

Additionally, ANA supports CMS's recommendation to publicly report eCQM performance data on Hospital Compare and/or data.edicare.gov, or any successor websites. ANA believes there is a direct correlation of quality nursing services and nurse staffing to patient outcomes, which can impact performance measures. When patients have a choice of facility, many choose facilities for the nursing care. Public reporting of eCQM performance measures will allow patients to have the data to make informed decisions about their care. However, we do caution that facilities must be able to evaluate and report additional burdens this creates. However, we do believe that because the measures are electronic, that data should be easily reported with limited burdens on facilities and staff.

3. ***Proposed Changes to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program (85 F.R. 32460, 32847)***

We are pleased to comment on the proposal to refine two existing measures, Catheter-associated Urinary tract infection (CAUTI) and Central Line-Associated Bloodstream Infection (CLABSI), for reporting by PPS-Exempt Cancer Hospital (PCHs). First, we support continued inclusion of these patient safety measures in the PCH Quality Reporting Program. We agree that reporting PCH CAUTI and CLABSI performance data is just as important as reporting acute care hospital CAUTI and CLABSI data. Prevention of CAUTI and CLABSI is a vitally important component of the overall goal of reducing and minimizing hospital-acquired infections (HAIs). We believe avoiding HAIs is an appropriate goal across all

[9] Centers for Disease Control and Prevention, Opioid Overdose, Prescription Drug Monitoring Programs (PDMPs). Last visited June 24, 2020. https://www.cdc.gov/drugoverdose/pdmp/states.html

hospitals, and that includes PCHs where safety concerns for patients with cancer and related conditions may be heightened. We also support the proposal for Medicare to revise the measure specifications for CAUTI and CLABSI for PCHs, to align with changes that have been made for other Medicare hospital reporting.

As with patient safety overall, nurses and nursing excellence play a major role in avoiding HAIs such as CAUTI and CLABSI. That is why these two nurse-sensitive indicators are included in the set of measures from which prestigious Magnet hospitals choose for reporting to the Magnet program. A Magnet hospital is a facility designated by the American Nurses Credentialing Center for its proven effective nursing leadership to improve patient outcomes. Magnet status has been found to be associated with lower rates of CLABSI.[10] To patients, Magnet recognition means the very best care, delivered by nurses who are supported to be the very best that they can be.[11]

ANA encourages reporting of nurse-sensitive measures throughout the healthcare system.[12] We believe such measures lead to a better understanding of the role of nurses in delivering high-quality care and advancing quality improvement goals. ANA further encourages CMS to consider all quality data that informs methods to reward nurses for their role in delivering high-value care.[13] The goals and achievements of value-based payment would be more robust by accounting for the role of nursing, and incentivizing nursing excellence.

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

Sincerely,

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[10] Barnes, Hilary et al. Magnet® Hospital Recognition Linked to Lower Central Line-Associated Bloodstream Infection Rates. Research in Nursing Health. 2016. Accessible online at https://onlinelibrary.wiley.com/doi/epdf/10.1002/nur.21709
[11] ANA Nursing World. ANCC Magnet Recognition Program. Accessible online at https://www.nursingworld.org/organizational-programs/magnet/
[12] Montalvo, I. The National Database of Nursing Quality Indicators™ (NDNQI®). OJIN: The Online Journal of Issues in Nursing. September 2007. Accessible online at https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No3Sept07/NursingQualityIndicators.aspx
[13] Lasater, Karen et al. Hospitals Known for Nursing Excellence Perform Better on Value Based Purchasing Measures. Policy, Politics, and Nursing Practice. November 2016. Accessible online at https://pubmed.ncbi.nlm.nih.gov/28558604/