May 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted Electronically to www.regulations.gov

Re: 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 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels [CMS-1765-P]

Dear Administrator Brooks-LaSure:

The American Nurses Association (ANA) is pleased to comment on the Centers for Medicare & Medicaid Services (CMS) Fiscal Year 2023 Prospective Payment System proposed rule for skilled nursing facilities (SNFs). Our comments address proposals to add quality measures to SNF reporting and performance programs, and responds to two Requests for Information (RFI) included in the Notice of Proposed Rulemaking (NPRM).

To summarize the comments below:

1. **ANA supports the inclusion of #NQF0431, vaccination of healthcare personnel (HCP), to the list of measures that SNFs are required to report through the Quality Reporting Program (QRP).**
2. **ANA recommends a blended approach to equity in Medicare that strives for overall equity improvement while targeting areas where disparities and patterns of inequity occur in SNF care.**
3. **ANA supports the addition of proposed measures to the SNF Value-Based Purchasing program (VBP), and urges CMS to implement payment models that account for the value of nursing care in SNFs.**
4. **ANA encourages CMS to incorporate ANA's core components of appropriate nurse staffing into minimum staffing standards for nursing facilities, especially components that emphasize the key roles of registered nurses (RNs) in direct care and interprofessional collaboration.**

1. **Reporting Flu Vaccination of Healthcare Personnel in SNFs**

ANA supports the inclusion of #NQF0431, vaccination of HCP, in the list of measures that SNFs are required to report through the QRP. As noted, this measure was first endorsed in 2008 and has been reviewed and tested in nursing facilities.

ANA's Position Statement on immunization states that all HCP, including RNs, should be vaccinated according to current recommendations of the Centers for Disease Control and Prevention and the

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Association for Professionals in Infection Control and Epidemiology.[1] ANA does not support any exemptions from immunization other than for documented medical contraindications.[2]

As noted in the NPRM, HCP employed in SNFs provide care to some of the most vulnerable people, including populations least likely to be vaccinated against the flu.[3] Racial and ethnic disparities in flu vaccination have been documented, as the NPRM further notes.[4] Vaccination of HCP can reduce risk of transmission from HCP to SNF. For these reasons, ANA concurs with CMS and members of the Measure Applications Partnership that regular reporting of influenza vaccination rates among SNF HCP will have a positive effect.[5] Recording and reporting will encourage SNFs to take responsibility for supporting HCPs' access to recommended immunizations, thereby contributing to overall infection control within the facility. We also encourage CMS to consider administrative and regulatory steps to ensure that staff immunizations are affordable and accessible.

The NPRM indicates that CMS is proposing to add #NQF0431 beginning with the FY2025 QRP. It is not clear why the measure cannot be added sooner. Flu season is anticipated as an annual occurrence nationally, and a public health infrastructure exists to distribute flu vaccine and support public education about the annual shot. Further, as noted in the NPRM, the data used to calculate the measure are standardized and interoperable. These factors support use of the measure in the QRP as soon as possible. We respectfully recommend that CMS consider implementation for 2023, and at the latest for 2024.

2. Advancing Equity in SNF Care

ANA fully supports CMS' commitment to achieving equity in health and care access, including for beneficiaries who need care in SNFs. The NPRM includes a RFI inviting feedback on principles and approaches for quality measurement and development to drive equity in SNF care, as well as additional thoughts about overarching considerations across CMS' QRP programs.

ANA recommends a blended approach to equity in Medicare that strives for overall equity improvement while targeting areas where disparities and patterns of inequity occur. CMS should identify and stratify equity measures appropriate for all QRP programs, based on common equity goals for Medicare and its beneficiaries overall. However, given the complexity of the program and diversity of patient needs, there can be no single "one size fits all" approach to equity. Therefore, CMS should also adopt strategies that consider the known similarities and differences of patients based on setting and provider type.

To drive equity in SNF care, specifically, ANA urges CMS to consider the multiple and layered factors that may lead to inequities in post-acute care. In addition to race, ethnicity, and age, these factors could include: Medicare SNF coverage in relation to length of stay; access to skilled nursing care in relation to geographic location; identified disparities related to local hospital discharges to post-acute settings; SNF employment of RNs and advanced practice registered nurses (APRNs) dedicated to care planning and

[1] https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/immunizations/
[2] Ibid.
[3] 87 FR 22720, 22747. April 15, 2022.
[4] Ibid.
[5] Measure Applications Partnership 2021-2022 Considerations for Implementing Measures in Federal Programs: Clinician, Hospital, and Post-Acute Care/Long-Term Care. National Quality Forum. March 2022.

management, as well as clinical care. CMS should also ensure that equity strategies for SNF care account for the voices of beneficiaries and their families, incorporating relevant patient-reported outcomes and experiences.[6]

ANA believes that RN staffing levels are always relevant in determinations related to quality and equity in SNF care. ANA's principles on nurse staffing sufficiency are highlighted in the NPRM. We discuss the separate RFI on minimum staffing below.

3. Expanding Value-Based Purchasing and Payment

Consistent with achieving quality and equity goals for SNF care, CMS should begin expanding the SNF value-based purchasing (VBP) program and implement additional value payment arrangements at an accelerated pace. ANA supports adding new measures to the SNF VBP program, as proposed in the NPRM. These include measures related to healthcare-associated infections, total nursing hours per patient day, and discharge to community. Deferrals and measure suppressions due to the coronavirus pandemic should be limited and narrow. SNFs currently have sufficient tools to prevent COVID-19 cases, such as access to vaccines and testing, and knowledge of effective protective supplies for patients and staff. There is no need for further delay in implementing CMS' agenda to hold Medicare providers accountable for delivering high-quality, high-value, cost-effective care.

In addition to adding measures to the current VBP program, CMS should aggressively explore new SNF payment models that account for the role of nursing care in achieving desired quality and cost outcomes. A starting point could be the CMS-funded Missouri Quality Intervention (MOQI) pilot. Led by an on-site APRN, MOQI provides direct care to residents and trains facility staff on tools to improve early assessment and intervention when residents' conditions change. One study of the MOQI model with 11 facilities over five years documented $32 million in savings from reduced hospitalizations.[7] ANA encourages CMS to pursue further a MOQI type of model that allows SNFs to employ APRNs and incentivizes them to do so.

4. Rulemaking on Minimum Staffing in Nursing Facilities

ANA applauds CMS' commitment to establishing a rule that will govern the level and type of staffing needed to ensure safe and quality care in nursing homes. In its RFI, CMS summarizes the results of existing research and analysis, and identifies some of the key information needed to advance this work. The RFI cites and quotes from ANA's 2020 Principles for Nurse Staffing.[8] We are pleased that this document is informing CMS' thinking about the role of registered nurses in nursing home quality. We

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[6] See National Academies of Sciences, Engineering, and Medicine (NASEM). The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff. 2022.

[7] Rantz, Marilyn, PhD, RN, FAAN et al. Better Care, Better Quality: Reducing Avoidable Hospitalizations of Nursing Home Residents. Journal of Nursing Care Quality. 2015. Available online at https://agingmo.com/wp-content/uploads/2017/10/JNCQ-MOQI-Reducing-Hosp-304-2015.pdf. See also University of Missouri Sinclair School of Nursing. MOQI and related items. Accessible online at https://nursinghomehelp.org/articlecategory/moqi-initiative/

[8] American Nurses Association. Principles for Nurse Staffing, 3rd Edition. 2020. Available online at https://www.nursingworld.org/PrinciplesForNurseStaffing

would like to draw CMS' further attention to our core components of appropriate nurse staffing to guide rulemaking on minimum staffing in nursing homes, including:

- Registered nurses are full partners working with other healthcare professionals in the collaborative, interprofessional delivery of safe, quality health care.
- All settings should have well-developed staffing guidelines with measurable nurse-sensitive outcomes specific to that setting and healthcare consumer population that are used as evidence to guide daily staffing.
- Registered nurses at all levels within a healthcare system must have a substantive and active role in staffing decisions to assure availability of the necessary time with patients to meet care needs and overall nursing responsibilities.[9]

In addition, ANA urges CMS to adopt recent recommendations of the National Academies of Sciences, Engineering, and Medicine, including the call for "direct-care RN coverage (in addition to the director of nursing) at a minimum of a 24-hour, 7-days per week basis, with additional RN coverage as needed."[10]

As noted in the comments above about the SNF VBP program, ANA also believes that APRN care is a high-value component of care in nursing facilities. We urge CMS to remove all federal barriers to APRN practice and employment in SNFs. ANA looks forward to engaging with CMS further in developing a minimum staffing rule for nursing homes.

ANA is the premier organization representing the interests of the nation's 4.3 million RNs, through its state and constituent member associations, organizational affiliates, and individual members. ANA members also include the four APRNs: NPs, clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). 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 conditions including essential self-care, and provide advice and emotional support to patients and their family members.

If you have any questions, please contact Brooke Trainum, Director of Policy and Regulatory Advocacy, at Brooke.Trainum@ana.org or (301) 628-5027.

Sincerely,

Debbie Hatmaker

Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer/EVP

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

[9] Ibid.
[10] NASEM. 2022

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