114TH CONGRESS  1ST SESSION

H. R. 2083

To amend title XVIII of the Social Security Act to provide for patient protection by establishing safe nurse staffing levels at certain Medicare providers, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 29, 2015

MRS. CAPPS (for herself, MR. JOYCE, MR. BLUMENAUER, MR. DANNY K. DAVIS of Illinois, MR. DEFAZIO, MR. LANGEVIN, MR. PAYNE, MR. PETERS, MR. SCHRADE, MS. SLAUGHTER, and MRS. TORRES) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To amend title XVIII of the Social Security Act to provide for patient protection by establishing safe nurse staffing levels at certain Medicare providers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Registered Nurse Safe Staffing Act of 2015”.

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SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Research shows that patient safety in hospitals is directly proportionate to the number of registered nurses working in the hospital. Higher staffing levels by experienced registered nurses are related to lower rates of negative patient outcomes.

(2) A 2011 study on nurse staffing and inpatient hospital mortality shows that sub-optimal nurse staffing is linked with a greater likelihood of patient death in the hospital. A 2012 study of serious patient events reported to the Joint Commission demonstrates that one of the leading causes of all hospital sentinel events is human factors, including staffing and staffing skill mix.

(3) Health care worker fatigue has been identified as a major patient safety hazard, and appropriate staffing policies and practices are indicated as an effective strategy to reduce health care worker fatigue and to protect patients. A national survey of registered nurses found that 74 percent experience acute or chronic effects of stress and overwork.

(4) A strategy that ensures optimal nurse staffing and skill mix greatly influences patient satisfaction and results in greater overall savings to hospitals through reductions in adverse patient events.
(5) A 2009 study demonstrated that improved patient satisfaction due to increased and appropriate nurse staffing is reflected on hospital scores on HCAHPS, which is a key measure for value-based payment programs under the Medicare program and used by other payors.

(6) Registered nurses play a vital role in preventing patient care errors. A 2009 study found that sufficient staffing of critical care nurses can prevent adverse patient events, which can cost anywhere from $2,200,000 to $13,200,000. By contrast, the nurse staffing costs in the study time period were only $1,360,000.

(7) Increasing the number of registered nurses can protect patients and yield a cost savings of nearly $3 billion, resulting from more than 4 million avoided extra stay days for adverse patient events, such as infection and bleeding occurring in the hospital, and by reducing costly hospital readmissions. Adding registered nurses to unit staffing has been shown to eliminate nearly one-fifth of all hospital deaths, and to reduce the relative risk of adverse patient events. Higher nurse staffing also generates cost savings to payors and eliminates a significant financial burden to the United States healthcare sys-
tem. This is demonstrated in the estimation in 2011 by the Centers for Disease Control and Prevention that there were 648,000 patients with 721,800 hospital acquired infections in United States acute care hospitals, costing hospitals an estimated $28.4 billion to $45 billion.

(8) A 2012 study of Pennsylvania hospitals shows that by reducing nurse burnout, which is attributed in part to poor nurse staffing, those hospitals could prevent an estimated 4,160 infections with an associated savings of $41,000,000. That study also found that for each additional patient assigned to a registered nurse for care, there is an incidence of roughly one additional catheter-acquired urinary tract infection per 1,000 patients or 1,351 infections per year, costing those hospitals as much as $1,100,000 annually.

(9) When hospitals employ insufficient numbers of nursing staff, registered nurses are being required to perform professional services under conditions that do not support quality health care or a healthful work environment for registered nurses.

(10) High readmission rates within a hospital system can be perceived as an overall indicator of poor quality care. In 2013, 17.5 percent of Medicare
beneficiaries were readmitted to a hospital within 30
days following discharge. These readmissions cost
Medicare an estimated $26 billion per year. Optimal
nurse staffing plays an important role in improving
quality care by ensuring nurses have adequate time
and resources to prepare each patient for discharge.

(11) As a payor for inpatient and outpatient
hospital services furnished to Medicare beneficiaries,
the Federal Government has a compelling interest in
promoting the safety of these patients by requiring
any hospital participating in the Medicare program
to establish minimum safe staffing levels for reg-
istered nurses.

SEC. 3. ESTABLISHMENT OF SAFE NURSE STAFFING LEV-
ELS BY MEDICARE PARTICIPATING HOS-
PITALS.

(a) REQUIREMENT OF MEDICARE PROVIDER AGRE-
EMENT.—Section 1866(a)(1) of the Social Security Act (42
U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (V), by striking “and” at
the end;

(2) in subparagraph (W), as added by section
3005 of the Patient Protection and Affordable Care
Act (Public Law 111–148)—
(A) by moving such subparagraph 2 ems to the left; and

(B) by striking the period at the end;

(3) in subparagraph (W), as added by section 6406(b) of the Patient Protection and Affordable Care Act (Public Law 111–148)—

(A) by moving such subparagraph 2 ems to the left;

(B) by redesignating such subparagraph as subparagraph (X); and

(C) by striking the period at the end and inserting “, and”; and

(4) by inserting after subparagraph (X), as redesignated by paragraph (3)(B), the following new subparagraph:

“(Y) in the case of a hospital (as defined in section 1861(e)), to meet the requirements of section 1899B.”.

(b) REQUIREMENTS.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

“NURSE STAFFING REQUIREMENTS FOR MEDICARE PARTICIPATING HOSPITALS

“Sec. 1899B. (a) IMPLEMENTATION OF NURSE STAFFING PLAN.—
“(1) IN GENERAL.—Each participating hospital shall implement a hospital-wide staffing plan for nursing services furnished in the hospital.

“(2) REQUIREMENT FOR DEVELOPMENT OF STAFFING PLAN BY HOSPITAL NURSE STAFFING COMMITTEE.—The hospital-wide staffing plan for nursing services implemented by a hospital pursuant to paragraph (1)—

“(A) shall be developed by the hospital nurse staffing committee established under subsection (b); and

“(B) shall require that an appropriate number of registered nurses provide direct patient care in each unit and on each shift of the hospital to ensure staffing levels that—

“(i) address the unique characteristics of the patients and hospital units; and

“(ii) result in the delivery of safe, quality patient care, consistent with the requirements under subsection (c).

“(b) HOSPITAL NURSE STAFFING COMMITTEE.—

“(1) ESTABLISHMENT.—Each participating hospital shall establish a hospital nurse staffing committee (in this section referred to as the ‘Committee’).
“(2) COMPOSITION.—A Committee established pursuant to this subsection shall be composed of members as follows:

“(A) MINIMUM 55 PERCENT NURSE PARTICIPATION.—Not less than 55 percent of the members of the Committee shall be registered nurses who provide direct patient care but who are neither hospital nurse managers nor part of the hospital administration staff.

“(B) INCLUSION OF HOSPITAL NURSE MANAGERS.—The Committee shall include members who are hospital nurse managers.

“(C) INCLUSION OF NURSES FROM SPECIALTY UNITS.—The members of the Committee shall include at least 1 registered nurse who provides direct care from each nurse specialty or unit of the hospital (each such specialty or unit as determined by the hospital).

“(D) OTHER HOSPITAL PERSONNEL.—The Committee shall include such other personnel of the hospital as the hospital determines to be appropriate.

“(3) DUTIES.—

“(A) DEVELOPMENT OF STAFFING PLAN.—The Committee shall develop a hospital-
wide staffing plan for nursing services furnished in the hospital consistent with the requirements under subsection (c).

“(B) Review and Modification of Staffing Plan.—The Committee shall—

“(i) conduct regular, ongoing monitoring of the implementation of the hospital-wide staffing plan for nursing services furnished in the hospital;

“(ii) carry out evaluations of the hospital-wide staffing plan for nursing services at least annually; and

“(iii) make such modifications to the hospital-wide staffing plan for nursing services as may be appropriate.

“(C) Additional Duties.—The Committee shall—

“(i) develop policies and procedures for overtime requirements of registered nurses providing direct patient care and for appropriate time and manner of relief of such registered nurses during routine absences; and
“(ii) carry out such additional duties as the Committee determines to be appropriate.

“(c) STAFFING PLAN REQUIREMENTS.—

“(1) PLAN REQUIREMENTS.—Subject to paragraph (2), a hospital-wide staffing plan for nursing services developed and implemented under this section shall—

“(A) be based upon input from the registered nurse staff of the hospital who provide direct patient care or their exclusive representatives, as well as the chief nurse executive;

“(B) be based upon the number of patients and the level and variability of intensity of care to be provided to those patients, with appropriate consideration given to admissions, discharges, and transfers during each shift;

“(C) take into account contextual issues affecting nurse staffing and the delivery of care, including architecture and geography of the environment and available technology;

“(D) take into account the level of education, training, and experience of those registered nurses providing direct patient care;
“(E) take into account the staffing levels and services provided by other health care personnel associated with nursing care, such as certified nurse assistants, licensed vocational nurses, licensed psychiatric technicians, nursing assistants, aides, and orderlies;

“(F) take into account staffing levels recommended by specialty nursing organizations;

“(G) establish upwardly adjustable minimum ratios of direct care registered nurses to patients for each unit and for each shift of the hospital, based upon an assessment by registered nurses of the level and variability of intensity of care required by patients under existing conditions;

“(H) take into account unit and facility level staffing, quality and patient outcome data, and national comparisons, as available;

“(I) ensure that a registered nurse shall not be assigned to work in a particular unit of the hospital without first having established the ability to provide professional care in such unit; and

“(J) provide for exemptions from some or all requirements of the hospital-wide staffing
plan for nursing services during a declared state of emergency (as defined in subsection (1)(1)) if the hospital is requested or expected to provide an exceptional level of emergency or other medical services.

“(2) LIMITATION.—A hospital-wide staffing plan for nursing services developed and implemented under this section—

“(A) shall not preempt any registered-nurse staffing levels established under State law or regulation; and

“(B) may not utilize any minimum number of registered nurses established under paragraph (1)(G) as an upper limit on the nurse staffing of the hospital to which such minimum number applies.

“(d) REPORTING AND RELEASE TO PUBLIC OF CERTAIN STAFFING INFORMATION.—

“(1) REQUIREMENTS FOR HOSPITALS.—Each participating hospital shall—

“(A) post daily for each shift, in a clearly visible place, a document that specifies in a uniform manner (as prescribed by the Secretary) the current number of licensed and unlicensed nursing staff directly responsible for patient
care in each unit of the hospital, identifying
specifically the number of registered nurses;

“(B) upon request, make available to the
public—

“(i) the nursing staff information de-
scribed in subparagraph (A);

“(ii) a detailed written description of
the hospital-wide staffing plan imple-
mented by the hospital pursuant to sub-
section (a); and

“(iii) not later than 90 days after the
date on which an evaluation is carried out
by the Committee under subsection
(b)(3)(B)(ii), a copy of such evaluation;
and

“(C) not less frequently than quarterly,
submit to the Secretary in a uniform manner
(as prescribed by the Secretary) the nursing
staff information described in subparagraph (A)
through electronic data submission.

“(2) SECRETARIAL RESPONSIBILITIES.—The
Secretary shall—

“(A) make the information submitted pur-
suant to paragraph (1)(C) publicly available in
a comprehensible format (as described in sub-
section (e)(2)(D)(ii)), including by publication on the Hospital Compare Internet Web site of the Department of Health and Human Services; and

“(B) provide for the auditing of such information for accuracy as a part of the process of determining whether the participating hospital is in compliance with the conditions of its agreement with the Secretary under section 1866, including under subsection (a)(1)(Y) of such section.

“(e) RECORDKEEPING; COLLECTION AND REPORTING OF QUALITY DATA; EVALUATION.—

“(1) RECORDKEEPING.—Each participating hospital shall maintain for a period of at least 3 years (or, if longer, until the conclusion of any pending enforcement activities) such records as the Secretary deems necessary to determine whether the hospital has implemented a hospital-wide staffing plan for nursing services pursuant to subsection (a).

“(2) COLLECTION AND REPORTING OF QUALITY DATA ON NURSING SERVICES.—

“(A) IN GENERAL.—The Secretary shall require the collection, aggregation, maintenance, and reporting of quality data relating to
nursing services furnished by each participating hospital.

“(B) USE OF ENDORSED MEASURES.—In carrying out this paragraph, the Secretary shall use only quality measures for nursing-sensitive care that are endorsed by the consensus-based entity with a contract under section 1890(a).

“(C) USE OF QUALIFIED THIRD-PARTY ENTITIES FOR COLLECTION AND SUBMISSION OF DATA.—

“(i) IN GENERAL.—A participating hospital may enter into agreements with third-party entities that have demonstrated expertise in the collection and submission of quality data on nursing services to collect, aggregate, maintain, and report the quality data of the hospital pursuant to subparagraph (A).

“(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to excuse or exempt a participating hospital that has entered into an agreement described in such clause from compliance with requirements for quality data collection, aggrega-
tion, maintenance, and reporting imposed under this paragraph.

“(D) REPORTING OF QUALITY DATA.—

“(i) PUBLICATION ON HOSPITAL COMPARE WEB SITE.—Subject to the succeeding provisions of this subparagraph, the Secretary shall make the data submitted pursuant to subparagraph (A) publicly available, including by publication on the Hospital Compare Internet Web site of the Department of Health and Human Services.

“(ii) COMPREHENSIBLE FORMAT.—Data made available to the public under clause (i) shall be presented in a clearly understandable format that permits consumers of hospital services to make meaningful comparisons among hospitals, including concise explanations in plain English of how to interpret the data, of the difference in types of nursing staff, of the relationship between nurse staffing levels and quality of care, and of how nurse staffing may vary based on patient case mix.
“(iii) Opportunity to Correct Errors.—The Secretary shall establish a process under which participating hospitals may review data submitted to the Secretary pursuant to subparagraph (A) to correct errors, if any, contained in that data submission before making the data available to the public under clause (i).

“(3) Evaluation of Data.—The Secretary shall provide for the analysis of quality data collected from participating hospitals under paragraph (2) in order to evaluate the effect of hospital-wide staffing plans for nursing services implemented pursuant to subsection (a) on—

“(A) patient outcomes that are nursing sensitive (such as pressure ulcers, fall occurrence, falls resulting in injury, length of stay, and central line catheter infections); and

“(B) nursing workforce safety and retention (including work-related injury, staff skill mix, nursing care hours per patient day, vacancy and voluntary turnover rates, overtime rates, use of temporary agency personnel, and nurse satisfaction).
“(f) Refusal of Assignment.—A nurse may refuse to accept an assignment as a nurse in a participating hospital, or in a unit of a participating hospital, if—

“(1) the assignment is in violation of the hospital-wide staffing plan for nursing services implemented pursuant to subsection (a); or

“(2) the nurse is not prepared by education, training, or experience to fulfill the assignment without compromising the safety of any patient or jeopardizing the license of the nurse.

“(g) Enforcement.—

“(1) Responsibility.—The Secretary shall enforce the requirements and prohibitions of this section in accordance with the succeeding provisions of this subsection.

“(2) Procedures for Receiving and Investigating Complaints.—The Secretary shall establish procedures under which—

“(A) any person may file a complaint that a participating hospital has violated a requirement of or a prohibition under this section; and

“(B) such complaints are investigated by the Secretary.

“(3) Remedies.—Except as provided in paragraph (5), if the Secretary determines that a partici-
pating hospital has violated a requirement of this section, the Secretary—

“(A) shall require the hospital to establish a corrective action plan to prevent the recurrence of such violation; and

“(B) may impose civil money penalties under paragraph (4).

“(4) CIVIL MONEY PENALTIES.—

“(A) IN GENERAL.—In addition to any other penalties prescribed by law, the Secretary may impose a civil money penalty of not more than $10,000 for each knowing violation of a requirement of this section, except that the Secretary shall impose a civil money penalty of more than $10,000 for each such violation in the case of a participating hospital that the Secretary determines has a pattern or practice of such violations (with the amount of such additional penalties being determined in accordance with a schedule or methodology specified in regulations).

“(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such
provisions apply to a penalty or proceeding under section 1128A.

“(C) Public notice of violations.—

“(i) Internet web site.—The Secretary shall publish on an appropriate Internet Web site of the Department of Health and Human Services the names of participating hospitals on which civil money penalties have been imposed under this section, the violation for which the penalty was imposed, and such additional information as the Secretary determines appropriate.

“(ii) Change of ownership.—With respect to a participating hospital that had a change in ownership, as determined by the Secretary, penalties imposed on the hospital while under previous ownership shall no longer be published by the Secretary of such Internet Web site after the 1-year period beginning on the date of the change in ownership.

“(5) Penalty for failure to collect and report quality data on nursing services.—
“(A) In General.—In the case of a participating hospital that fails to comply with requirements under subsection (e)(2) to collect, aggregate, maintain, and report quality data relating to nursing services furnished by the hospital, instead of the remedies described in paragraph (3), the provisions of subparagraph (B) shall apply with respect to each such failure of the participating hospital.

“(B) Penalty.—In the case of a failure by a participating hospital to comply with the requirements under subsection (e)(2) for a year, each such failure shall be deemed to be a failure to submit data required under section 1833(t)(17)(A), section 1886(b)(3)(B)(viii), section 1886(j)(7)(A), or section 1886(m)(5)(A), as the case may be, with respect to the participating hospital involved for that year.

“(h) Whistleblower Protections.—

“(1) Prohibition of Discrimination and Retaliation.—A participating hospital shall not discriminate or retaliate in any manner against any patient or employee of the hospital because that patient or employee, or any other person, has pre-
sented a grievance or complaint, or has initiated or
cooperated in any investigation or proceeding of any
kind, relating to—

“(A) the hospital-wide staffing plan for
nursing services developed and implemented
under this section; or

“(B) any right, other requirement or pro-
hibition under this section, including a refusal
to accept an assignment described in subsection
(f).

“(2) RELIEF FOR PREVAILING EMPLOYEES.—
An employee of a participating hospital who has
been discriminated or retaliated against in employ-
ment in violation of this subsection may initiate judi-
cial action in a United States district court and shall
be entitled to reinstatement, reimbursement for lost
wages, and work benefits caused by the unlawful
acts of the employing hospital. Prevailing employees
are entitled to reasonable attorney’s fees and costs
associated with pursuing the case.

“(3) RELIEF FOR PREVAILING PATIENTS.—A
patient who has been discriminated or retaliated
against in violation of this subsection may initiate
judicial action in a United States district court. A
prevailing patient shall be entitled to liquidated
damages of $5,000 for a violation of this statute in addition to any other damages under other applicable statutes, regulations, or common law. Prevailing patients are entitled to reasonable attorney’s fees and costs associated with pursuing the case.

“(4) LIMITATION ON ACTIONS.—No action may be brought under paragraph (2) or (3) more than 2 years after the discrimination or retaliation with respect to which the action is brought.

“(5) TREATMENT OF ADVERSE EMPLOYMENT ACTIONS.—For purposes of this subsection—

“(A) an adverse employment action shall be treated as discrimination or retaliation; and

“(B) the term ‘adverse employment action’ includes—

“(i) the failure to promote an individual or provide any other employment-related benefit for which the individual would otherwise be eligible;

“(ii) an adverse evaluation or decision made in relation to accreditation, certification, credentialing, or licensing of the individual; and

“(iii) a personnel action that is adverse to the individual concerned.
“(i) Relationship to State Laws.—Nothing in this section shall be construed as exempting or relieving any person from any liability, duty, penalty, or punishment provided by the law of any State or political subdivision of a State, other than any such law which purports to require or permit any action prohibited under this title.

“(j) Relationship to Conduct Prohibited Under the National Labor Relations Act or Other Collective Bargaining Laws.—Nothing in this section shall be construed as—

“(1) permitting conduct prohibited under the National Labor Relations Act or under any other Federal, State, or local collective bargaining law; or

“(2) preempting, limiting, or modifying a collective bargaining agreement entered into by a participating hospital.

“(k) Regulations.—

“(1) In General.—The Secretary shall promulgate such regulations as are appropriate and necessary to implement this section.

“(2) Implementation.—

“(A) In General.—Except as provided in subparagraph (B), as soon as practicable but not later than 2 years after the date of the enactment of this section, a participating hospital
shall have implemented a hospital-wide staffing plan for nursing services under this section.

“(B) Special rule for rural hospitals.—In the case of a participating hospital located in a rural area (as defined in section 1886(d)(2)(D)), such participating hospital shall have implemented a hospital-wide staffing plan for nursing services under this section as soon as practicable but not later than 4 years after the date of the enactment of this section.

“(l) Definitions.—In this section:

“(1) Declared state of emergency.—The term ‘declared state of emergency’ means an officially designated state of emergency that has been declared by the Federal Government or the head of the appropriate State or local governmental agency having authority to declare that the State, county, municipality, or locality is in a state of emergency, but does not include a state of emergency that results from a labor dispute in the health care industry or consistent understaffing.

“(2) Participating hospital.—The term ‘participating hospital’ means a hospital (as defined in section 1861(e)) that has entered into a provider agreement under section 1866.
“(3) PERSON.—The term ‘person’ means one or
more individuals, associations, corporations, unincor-
porated organizations, or labor unions.

“(4) REGISTERED NURSE.—The term ‘reg-
istered nurse’ means an individual who has been
granted a license to practice as a registered nurse in
at least 1 State.

“(5) SHIFT.—The term ‘shift’ means a sched-
uled set of hours or duty period to be worked at a
participating hospital.

“(6) UNIT.—The term ‘unit’ means, with re-
spect to a hospital, an organizational department or
separate geographic area of a hospital, including a
burn unit, a labor and delivery room, a post-anes-
thesia service area, an emergency department, an
operating room, a pediatric unit, a stepdown or in-
termediate care unit, a specialty care unit, a telem-
etry unit, a general medical care unit, a subacute
care unit, and a transitional inpatient care unit.”.

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