PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 10, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1765-P

Submitted electronically to: http://www.regulations.gov

Re: CMS-1746-P, 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

Dear Administrator Brooks-LaSure:

On behalf of the Premier healthcare alliance uniting more than 4,400 U.S. hospitals and health systems and approximately 225,000 other providers and organizations, we appreciate the opportunity to submit comments on the *"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)"* proposed rule, which was published in the April 15, 2022 *Federal Register*.

With integrated data and analytics, collaboratives, supply chain solutions, and consulting and other services, Premier enables better care and outcomes at a lower cost. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Through its Continuum of Care division, Premier serves more than 400 long-term care pharmacies and over 28,000 nursing homes nationwide.

In our comments, Premier urges CMS to:

- Monitor the Patient Driven Payment Model (PDPM) and make no parity adjustment for FY 2023. CMS should not implement any parity adjustment until FY 2024 at the earliest, after which time the adjustment should be phased in with a limit of no more than 1 percent per year;
- Invest in interoperable technology in nursing homes and other long-term and post-acute care (LTPAC) settings
    - Take a comprehensive approach to the transfer of health information by focusing on efforts to advance interoperability across the care continuum via electronic data exchange;
    - Enhance efforts to develop standards and measures for data exchange and sharing across all care settings, including skilled nursing facilities (SNFs);
    - Explore policy options to incentivize SNFs to adopt electronic clinical surveillance technology to reduce and prevent healthcare associated infections (HAIs);
- Consider adjustments to the SNF prospective payment system (PPS) in response to stakeholder input on how COVID affects the relative staff time resources necessary for treating patients in isolation due to infection;
- Strengthen the completeness and quality of data submissions under the Quality Reporting Program (QRP) and include appropriate financial incentives to SNFs so they can invest in technologies that improve patient safety and compliance with data submission thresholds under the QRP;
- Apply a 0.0 percent withhold for the SNF Value-based Purchasing (VBP) Program in FY 2023;
- Not consider the COVID-19 Vaccination Coverage Among Healthcare Personnel measure for future adoption at this time;

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- Focus efforts on workforce improvement programs, rather than establishing unrealistic staffing requirements or penalizing SNFs for staffing turnover; and
- Address healthcare disparities through quality measure development.

I. PDPM PARITY ADJUSTMENT

Premier shares the concerns of CMS and many other stakeholders regarding the fiscal instability of Skilled Nursing Facilities (SNFs) resulting from the combined effects of the COVID-19 public health emergency (PHE) and the new Patient Driven Payment Model (PDPM) that was implemented in FY 2019, just months before the PHE began. Given the historic nature of the ongoing COVID-19 PHE and its disproportionate fiscal effects on SNFs, reliable analysis to inform a recalibration of the PDPM appears to be unattainable at this juncture. Further, any disruption to the PDPM that results in significant payment fluctuations is likely to have unintended consequences on direct patient care as the facilities and other ancillary providers, such as LTCPs, are impacted by payment reductions. Therefore, CMS should reconsider whether its recalibration methodology appropriately estimates what the case mix distribution would have been absent the COVID-19 PHE and forego recalibration until there is a higher degree of confidence in the estimate. Should CMS decide to proceed with recalibration without further methodological validation, it should advance mitigation strategies to prevent significant disruptions to patient care and SNF and other ancillary provider operations.

Premier recognizes that statutory constraints may limit the actions CMS may take and therefore, ***we urge CMS to continue to monitor the PDPM and make no parity adjustment for FY 2023. Further, CMS should not implement any parity adjustment until FY 2024 at the earliest, after which time the adjustment should be phased in with a limit of no more than 1 percent per year.*** As CMS has done in the past with historic disruptions to providers, we urge CMS to use its discretion to ensure reimbursement predictability so that SNFs can continue to care for patients both during and after the COVID-19 PHE.

II. INVESTMENT NEEDED FOR INTEROPERABLE TECHNOLOGY IN NURSING HOMES

Comprehensive Approach to the Transfer of Health Information

As an overarching theme, Premier urges CMS to take a comprehensive approach to the transfer of health information by focusing on additional efforts to advance interoperability across the care continuum via electronic data exchange. Ensuring interoperability across electronic health record (EHR) systems and settings of care can unlock barriers to data sharing and care coordination between health systems, physician group practices, independent physicians, and post-acute care (PAC) settings. CMS' pilot testing of the proposed measures confirms that the most common mode of information transmission to the patient and to the provider was paper based[1]. This long-standing reliance on paper-based transmission of information presents a significant barrier for PAC providers to implement EHR systems. Additional barriers for PAC providers to adopt EHR systems include a lack of financial incentives under the Health Information Technology for Economic and Clinical Health (HITECH) ACT and no mandated EHR adoption requirements. As a result, many SNFs and other PAC providers are not using EHRs or are using EHRs that are not designed for interoperability[2].

We urge CMS to enhance its efforts to develop standards and measures for data exchange and sharing across all care settings, including SNFs. The transfer of information between providers most often occurs via cumbersome and resource-intensive manual processes. CMS should consider ways to incentivize PAC providers to more readily adopt health IT in support of wider efforts to standardize patient data, improve care quality, and reduce costs. Standardized data elements and common data reporting processes alone will not achieve interoperability across the care continuum.

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1 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Transfer-of-Health-Information-2018-Pilot-Test-Summary-Report_Final.pdf

2 https://www.newswire.com/news/post-acute-care-the-next-frontier-for-health-systems-under-risk-black-20056199

Electronic Clinical Surveillance Technology as a Solution for SNFs

Premier agrees that a critical need exists for preventing and reducing healthcare associated infections (HAIs) across the healthcare system and supports CMS efforts to advance measures to assess HAIs in SNFs. One step further, we believe CMS should pursue mechanisms that will reduce HAIs in the first place and lead to better quality outcomes. In the acute care setting, Premier is an established leader in implementing clinical surveillance systems to help translate data into action to improve patient outcomes. Premier continues to focus on clinical analytics technologies that detect patient care issues with the surveillance, interventions and reporting capabilities that are needed to support antimicrobial stewardship programs that reduce HAIs. More than 1,000 facilities use Premier's clinical surveillance technology, powered by TheraDoc®, that delivers a comprehensive, easy-to-use solution that helps clinicians individualize antibiotic therapy. The clinical surveillance system utilizes data from EHRs, helping clinicians and pharmacists identify overuse of antibiotics and drug-bug mismatches, reduce time-to-appropriate therapy and enhance therapy for difficult-to-treat pathogens. Based on the success in acute care settings, we believe SNFs would benefit by implementing clinical surveillance systems that would allow them to:

- Discontinue medications where there was a drug-bug mismatch or where unnecessary;
- Prevent adverse drug events;
- Switch from intravenous medications to less expensive oral formulas;
- Eliminate redundant antimicrobials;
- Switch patients to narrower and less expense antimicrobials;
- Shorten the duration of drug therapy to align with recommended guidelines; and
- Restrict the use of certain drugs without approval of an infectious disease specialist.

Unfortunately, clinical analytics technologies are currently not widely used in SNFs because of financial barriers to entry. SNFs should have the same access to tools that will help them combat infection spread during any future outbreaks of COVID-19 and during their day-to-day operations. ***Therefore, in addition to measure development, Premier urges CMS to explore policy options to incentivize SNFs to adopt electronic clinical surveillance technology to reduce and prevent HAIs.***

III. REQUEST FOR INFORMATION: INFECTION ISOLATION UNDER THE SNF PPS

Premier commends CMS for soliciting stakeholder input regarding the patient characteristics of isolation due to an active infection, which is used to classify patients into payment groups under the SNF PPS. The COVID-19 PHE is clearly causing significant increases in staff time and resources necessary for treating patients who reside in SNFs. Further, the nature of COVID requires an increase in staff time and resources to protect and care for all patients within a SNF, including those with an active infection as well as all other patients. Even after the PHE, high staff time and resources will persist, as protecting SNF patients from COVID and other infections will continue to be a priority. ***Premier encourages CMS to consider adjustments to the SNF PPS in response to stakeholder input on how COVID-19 affects the relative staff time and resources necessary for treating patients in isolation due to infection. We also urge CMS to incentivize SNFs to adopt electronic clinical surveillance technology to support the appropriate and efficient care for patient who may have an active infection or are at risk for infection. Premier strongly believes these tools are necessary moving forward to protect patients residing in SNFs.***

IV. SNF QUALITY REPORTING PROGRAM

For the SNF QRP, CMS proposes revisions to regulation text to accompany the Healthcare Personnel (HCP) COVID-19 Vaccine measure previously finalized for adoption for program year FY 2024. The revised text would also be applicable to the Influenza Vaccination HCP measure as proposed for FY 2025, if finalized. Importantly, this proposal recognizes the significance of infection safety in SNFs through revised text that would consolidate and clarify the data completeness thresholds that SNFs would be required to reach in order to be eligible for the full SNF PPS annual update. Data submission for these measures is through the CDC's National Health Safety

Network (NHSN) where the CDC processes the data, calculates measure results, and then transmits results to CMS. The revised regulation text would codify that the data completeness threshold for all QRP measures reported through the NHSN is 100 percent while the threshold for measure data and SPADEs submitted through the Minimum Data Set (MDS) is 80 percent.

Premier supports CMS efforts to improve infection safety in SNFs through changes to the QRP that strengthen the completeness and quality of data submissions. However, we believe it is critical that these changes must be accompanied with appropriate financial incentives to SNFs so they can invest in technologies, including electronic clinical surveillance technology, that improve patient safety and compliance with data submission thresholds under the QRP.

V. SNF VALUE-BASED PURCHASING (VBP) PROGRAM

SNF Value-Based Incentive Payments for the FY 2023 Program Year

In response to the COVID-19 PHE, CMS proposes changes to the SNF VBP Program including the suppression of the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) for the FY 2023 SNF VBP Program Year. Additionally, CMS proposes to: not assign relative rankings to SNFs eligible to participate in the Program; reduce each eligible facility's adjusted federal per diem rate by 2 percentage points per statute as usual (the withhold); and award back to each eligible facility 60 percent of their 2 percent withhold, resulting in a 1.2 percent payback. CMS further proposes that SNFs failing to meet SNFRM minimums for program year FY 2023 will be excluded from the program for that year. CMS reiterates its goal to resume use of the pre-pandemic scoring methodology for the FY 2024 program year.

Premier applauds CMS for recognizing the disruptions caused by the COVID-19 PHE, and encourages CMS to maximize regulatory discretion in an effort to stabilize SNF reimbursement. We urge CMS to apply a 0.0 percent withhold for the SNF VBP in FY 2023. If CMS determines FY 2023 SNF VBP adjustments must be done, Premier encourages CMS advance a methodology to apply cuts that result in a 70 percent return of the 2 percent withhold, which is allowed in statute. Thus, the flat cut would be closer to 0.6 percent and not the 0.8 percent CMS has proposed.

SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI) Measure for FY 2026 Implementation

Premier fully supports efforts to reduce HAIs, recognizing that many HAIs are potentially preventable and associated with longer lengths of stay, higher healthcare costs, use of higher-intensity care, and increased mortality. During the development process of the measure for HAIs Requiring Hospitalizations, CMS has made improvements based on comments from Premier and other stakeholders. Notably, the HAI measure would compare SNFs to their peers to statistically separate those that perform better than or worse than each other in infection prevention. While Premier believes the peer comparison would encourage SNFs to improve in the area of HAI prevention and management, we have concerns about the timing of implementation for the measure due to the unknown effects of the COVID-19 PHE on SNFs. Given the tremendous pressure placed on SNFs during the PHE and the fact that each SNF continues to be disrupted by COVID-19 in different ways, we believe the HAI should be advanced, but in a way that allows CMS to evaluate the stability of the measure and does not penalize SNFs until well after the PHE has expired. ***Premier suggests CMS consider collecting the HAI data, but not initially reporting it publicly. An incremental approach will afford SNFs adequate time to prepare for a fully implemented, publicly available measure.***

Future VBP Expansion

Premier supports the expansion of the SNF VBP to include additional measures and encourages CMS to rely on measures from the SNF QRP in this process. This approach is consistent with the structure for the Inpatient Prospective Payment System where QRP measures migrate to the VBP after being fully vetted, tested and evaluated.

CMS requests comments as to whether the VBP should be expanded in the future to include the COVID-19 Vaccination Coverage Among Healthcare Personnel measure. ***Premier believes this measure should not be considered for future adoption at this time.*** First, it is still unknown if individuals will need to receive annual COVID-19 vaccines or booster shots. As a result, the measure specifications for a COVID-19 vaccination measure are likely to change as the definition of a completed COVID-19 vaccination course changes overtime. Secondly, rates of vaccination will be largely dependent on factors outside a SNF's control, such as where the facility is located and personal preference of the facility's staff. Vaccine hesitancy has varied significantly across states. Additionally, state, local, and even individual health system policies governing COVID-19 vaccinations also vary. Some facilities are requiring that all staff receive the vaccine, while some facilities are located in states or localities where political pressure prevents them from setting a mandatory vaccine policy. Some personnel have indicated a preference to wait until the vaccine receives full Food and Drug Administration (FDA) approval before receiving it. Further, CMS' interim final rule, CMS–3414–IFC, requires LTC facilities report on a weekly basis the COVID-19 vaccination status of residents and staff, total numbers of residents and staff vaccinated, each dose of vaccine received, COVID-19 vaccination adverse events, and therapeutics administered. CMS is already requiring SNFs to report weekly vaccination data of residents and staff to the NHSN, so we caution that this measure could impose duplicative penalties and burden for facilities.

Several proposals and RFIs in the proposed rule address SNF staffing. CMS requests comment regarding future inclusion in the VBP of a staffing turnover measure. Additionally, the proposal includes an RFI on establishing minimum staffing requirements for SNFs. If CMS moves forward with the 5 percent cut to the PDPM in its push for budget neutrality, SNFs will face even greater pressure balancing fiscal and labor challenges. According to the Kaiser Family Foundation, as of the week ending March 20, 2022, 28 percent of nursing facilities reported at least one staffing shortage (approximately 3,900 out of 14,000 facilities)[3]. Given the current shortages and instability in the health care labor market and that we are still in the COVID-19 PHE, ***Premier urges HHS to focus efforts on workforce improvement programs, rather than establishing unrealistic staffing requirements or penalizing SNFs for staffing turnover.***

VI. HEALTH EQUITY

Measuring Healthcare Quality Disparities Across CMS Quality Programs

Reducing disparities in care and achieving health equity across communities requires a holistic approach to care, shifting the incentives in our health system from sickness-based to wellness-based**. When providers are responsible for total cost of care for their patients and have flexibility to address social determinants of health, providers will be proactive in addressing inequity and disparities.** Addressing the underlying social and economic inequities as well as systemic barriers and biases that drive disparities in care requires (1) data collection and monitoring of key outcomes and health equity measures and (2) shifting the payment system to account for a more comprehensive set of services that address disparities. We appreciate CMS' commitment to closing health equity gaps in the CMS quality programs and look forward to partnering with CMS in this area.

CMS continues to seek input on addressing disparities across the CMS quality programs. In the proposed rule, CMS seeks input on key principles the agency should consider when addressing disparities through quality measure development. These principles are stratified into five key categories.

We recommend that all efforts to stratify measures by race, ethnicity and social factors begin with confidential reporting and appropriate risk adjustment to account for factors associated with outcomes that cannot be addressed by providers. We must avoid a perverse cycle, wherein certain policies – such as public reporting of stratified quality data – discourages beneficiaries from visiting providers that care for patients

[3] https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/

in marginalized communities, subsequently leading to unequal care for those patients due to lack of equal resources to treat them. It is critical that information publicly shared on disparities in care is accurate and can be understood by consumers. Moreover, while stratification and comparing providers with similar populations helps identify opportunities for improvement, it does not provide providers with all the tools necessary to address any underlying factors contributing to health inequities. **These efforts must be combined with a broader set of supports to enable providers to respond to disparities in care**, such as learning networks and data on available community support services. Finally, we must recognize the challenges of stratifying measures that do not have adequate sample size. CMS must recognize the need for increased patient-level data and the associated burden to collect and report that information. **Overall, we support the principles outlined for stratifying measure results and offer additional perspectives on each principle below.**

Goals and Approaches for Measuring Disparities using Stratification. CMS discusses the within- and between-provider methodological approaches for comparing measures results. **We support using both approaches**, which has also been recommended by the Assistant Secretary for Planning and Evaluation.

Selecting and Prioritizing Measures for Disparity Reporting. CMS discusses measures that could be prioritized including existing measures; measures with identified disparities; measures with reliable and representative comparisons; and outcome, access, and appropriateness measures. We agree with these principles and encourage CMS to be transparent about why certain measures were selected for disparity reporting. CMS should use its existing processes (e.g., NQF endorsement, Measures Applications Partnership, and Notice of Proposed Rule Making) to seek stakeholder input before measures are stratified. Additionally, as we note above, CMS should first employ confidential reporting and seek additional feedback prior to public reporting.

Social Risk Factors and Demographic Data Collection. CMS notes that patient reported data is the gold standard and discusses other potential data sources, including billing and administrative data, area-based indicators of social risk and demographics, and imputed sources of social risk and patient demographics.

Health systems are currently capturing sociodemographic data, but this information is not easily translatable for CMS purposes. For example, despite an available framework for mapping the more than 900 race ethnicity codes provided by the CDC to the OMB, race and ethnicity codes captured in the EHR cannot be consistently mapped. This is a result of lack of use of standard taxonomies—in part by the EHRs and in part by the providers to allow the category selections to align with how their populations would like to report information. Similarly, there are an abundance of tools to screen for social determinants of health (SDOH) with underlying definitions for certain social risk factors (e.g., food insecurity) significantly varying even when the same tool is used by different providers.

The Agency for Healthcare Research and Quality (AHRQ) has found that one of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time. AHRQ further found that the principal challenges in obtaining race, ethnicity, and language data for use in quality improvement assessments include a lack of standardization and understanding of why the data are being collected.

We ask that CMS make a concerted effort to advance standards for the collection of socio-demographic information, using existing tools such as the United States Core Data for Interoperability (USCDI), Z-codes, HL7 and Fast Healthcare Interoperability Resources (FHIR) standards. As we note above, CMS needs a coordinated approach for using sociodemographic data for numerous purposes including payment and quality. This coordinated approach requires significant input from providers across the continuum, vendors,

payers, and suppliers. **We recommend that CMS convene a dedicated Task Force or Expert Panel of stakeholders to support advancing standards and collection of socio-demographic factors.**

We do not support the use of indirect estimation techniques due to data inaccuracy. Health systems are currently collecting self-reported sociodemographic data from their populations through a variety of methods. Inaccurate measure stratification can disrupt ongoing efforts to improve disparities in care. **Instead, we urge CMS to rapidly and meaningfully pursue efforts to improve access to directly collected race and ethnicity data from self-reported sources.**

Finally, **we support using area-based indicators of social risk as an initial step in providing hospitals confidential feedback**. As noted above, health systems are currently working to identify disparities in their populations. Having measure rates using area indices will allow hospitals to compare their own stratified results to stratified results based on the area indices. This provides valuable information on how provider population or performance may vary from the region.

Identification of Meaningful Performance Differences. CMS notes several approaches for detecting meaningful differences in stratified results. As we note above, we encourage CMS to approach stratification of measures results similar to approaches used for collection and reporting of all measure results. CMS should convene a Technical Expert Panel.

Reporting Disparity Results. CMS discusses a goal of confidential reporting to providers for new programs and measures. **We agree with this approach and reiterate that CMS should seek stakeholder input prior to public reporting.**

VII. CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the *"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)"* proposed rule. Premier looks forward to working with CMS and other stakeholders to develop reforms that meet the agency's goals and are appropriate for beneficiaries and providers.

If you have any questions regarding our comments or need more information, please contact Shara Siegel, Director of Government Affairs, at shara_siegel@premierinc.com or 646.484.0905.

Sincerely,

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