May 23, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1802-P

Submitted electronically to: http://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 2025 [Docket Number CMS-1802-P]

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates 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 2025 (CMS-1802-P)"* proposed rule which was published in the April 3, 2024 *Federal Register*.

Premier responds to several key areas in the proposed rule, including the need for interoperable technology in nursing homes, as well as the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) and the Value-based Purchasing (VBP) Program. Specifically, 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, including SNFs, via electronic data exchange.
- Test, refine, and advance valid measures for both the SNF QRP and VBP Program to advance health equity.
- Continue efforts to collect social determinants of health data across care settings as part of the SNF QRP; and
- Develop consistent methodology for measuring health equity that is applicable across all care settings, including SNFs, in Medicare VBP programs.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 2.7 billion hospital outpatient and clinic encounters and 177 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. INVESTMENT NEEDED FOR INTEROPERABLE TECHNOLOGY IN NURSING HOMES

For many years, the U.S. Department of Health and Human Services (HHS) has focused on policies that encourage and support the adoption of interoperable health information technology. While these efforts have included significant financial incentives for many providers, skilled nursing facilities (SNFs) have not been eligible for these incentives. ***As an overarching theme, Premier urges the Centers for Medicare & Medicaid Services (CMS) to take a comprehensive approach to the transfer of health information by focusing on additional efforts to advance interoperability across the care continuum, including SNFs, 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 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]

Premier urges 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.

Premier also agrees with CMS 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 prevent and reduce HAIs 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;

[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

- 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 as acute care providers to tools that will help them combat infection spread during any future outbreaks of COVID 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. SNF QUALITY REPORTING PROGRAM (QRP)

Proposed Social Determinants of Health Data Elements

CMS proposes, beginning for the FY 2027 SNF QRP, to collect through the Minimum Data Set (MDS) four new items as standardized patient assessment data elements (SPADEs) under the social determinants of health (SDOH) category: one item for living situation, two items for food, and one item for utilities. If finalized, the four new SPADEs would be added to the seven items currently in the SDOH category: ethnicity, race, preferred language, interpreter services, health literacy, transportation, and social isolation.

Premier supports CMS' efforts to improve care and 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 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. Further, ***Premier supports CMS' efforts to collect SDOH data across care settings, including SNFs. Recognizing that these elements are critical when considering health equity, we encourage CMS to continue its work to test, refine, and advance valid measures for the SNF QRP.***

Quality Measure Concepts Under Consideration – Composite Measure of Vaccinations

CMS requests information on quality measure concepts under consideration for the future including a composite measure of vaccinations. In past comments to CMS, Premier has raised concerns about utilizing vaccine-based measures because they may not capture quality in SNFs. These concerns with measure validity are rooted in several dynamics. First, there are numerous reasons beyond health contraindications that patients may decide whether to receive vaccinations. Further, rates of vaccination are largely dependent on factors outside a SNF's control, such as where the facility is located and personal preference of the residents. Additionally, state, local, and even individual health system policies governing vaccinations vary. Some facilities may require vaccinations, while others are located in states or localities that prevent them from setting a mandatory policy. Taken together, these factors confound the use of vaccine-based measures to capture SNF quality.

We are also concerned about the implications of a composite vaccination calculation including short stay Part A patients. This dynamic places SNFs in the difficult position of accepting patients for admission who are not up to date with vaccinations, knowing that this will result in the SNF receiving a lower quality score on this measure. Under this scenario, a SNF could be incentivized to not offer admission to these patients. Alternatively, these patients may be admitted and then receive vaccinations during their short stay, even when vaccine administration may increase the risk of adverse health outcomes during a vulnerable care setting transition. ***Premier believes that adoption of vaccine-based measures into the SNF QRP is problematic given concerns with the validity of measuring SNF quality.***

IV. SNF VALUE-BASED PURCHASING (VBP) PROGRAM

Future Measure Considerations

While CMS is not proposing any new measures or measure set adjustments in this rule, it seeks feedback on potential new measure topics and measure set adjustments, including resident experience measures and other measures that address interoperability and health equity/social determinants of health, as well as the feasibility of a staffing composite measure. ***Premier supports CMS' efforts to advance measures within the SNF VBP that appropriately incentivize and financially reward high-performing SNFs.*** A critical component of this is the Measures Under Consideration (MUC) process that ensures public input is taken into to account when developing and refining VBP measures.

Potential Next Steps for Health Equity

In previous rulemaking, CMS adopted a Health Equity Adjustment (HEA) policy, supported by Premier, that beginning in FY 2027 will reward SNFs that perform well and whose resident population during the performance period include at least 20 percent of residents with dual eligibility status (DES). CMS is now seeking feedback on different ways of measuring health equity that could be incorporated into the SNF VBP Program, such as a health-equity focused measure, composite measure, or metrics for SNFs to earn bonus points on their performance score.

Premier supports CMS' efforts to reward SNFs with a HEA that are able to overcome the challenges of caring for high proportions of residents with DES while still providing high quality care. Recognizing that DES is one of many elements when considering health equity, ***Premier encourages CMS to continue its work to test, refine, and advance additional measures that produce a valid health equity measures for the VBP. Prior to moving forward with health equity measures for SNFs, Premier encourages CMS to first assess the impact of health equity measures CMS has implemented in non-SNF care settings. Through this process CMS should develop consistent methodology for measuring health equity that is applicable across all care settings, including SNFs.***

V. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on the FY 2025 SNF proposed rule (CMS-1802-P). Premier looks forward to working with CMS and other stakeholders to develop reforms that meet the agency's goals and are in the best interest of beneficiaries and providers.

If you have any questions regarding our comments or need more information, please contact Melissa Medeiros, Senior Director of Policy, at melissa_medeiros@premierinc.com or 202.897.4107.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.