September 16, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3347-P

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

Re: CMS–3347–P, Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency, and Transparency

Dear Administrator Verma:

The Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, 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. Innovatix, a wholly-owned subsidiary of Premier, is one of the nation's largest non-acute care group purchasing organizations that delivers savings and value to long-term care pharmacies (LTCPs), skilled nursing facilities (SNFs) and other provider organizations. Together, Premier and Innovatix serve more than 650 LTCPs, 6,525 SNFs, 4,000 hospitals and approximately 165,000 other providers.

We appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule titled "*Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency, and Transparency*." The proposed rule would reform the Medicare and Medicaid long-term care requirements that CMS has identified as unnecessary, obsolete, or excessively burdensome.

Premier supports CMS' efforts to implement policies that will simplify and streamline the current long-term care facility (LTCF) requirements, while also allowing LTCFs to focus on providing high-quality healthcare to their residents. We encourage CMS to work with stakeholders to ensure any final proposals are communicated and implemented in a timeframe that is feasible.

PHARMACY SERVICES (§ 483.45)

CMS proposes to remove the existing requirement that Pro re Nata (PRN), or as needed, prescriptions for psychotropic medications cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. The proposal is intended to provide flexibility to allow for PRN orders of psychotropic medications to be extended beyond 14-days if the attending physician or prescribing practitioner believes it appropriate and documents his or her rationale in the resident's medical record and indicates the duration for the PRN order.

We support the proposal since it will create a pathway to extend PRN orders for psychotropic drugs beyond the current 14–day limit when appropriate. We believe this proposal creates the appropriate balance to support medical professionals in exercising their professional judgment in providing patient-specific care, while protecting residents. Furthermore, the proposal will help address physician/prescriber

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access concerns for rural and other underserved providers regarding timely access to appropriate medications.

PHASE 3 IMPLEMENTATION OF OVERLAPPING REGULATORY PROVISIONS

CMS proposes to delay implementation of some Phase 3 requirements for one year after the effective date of finalization of the rule. **Premier supports CMS' goal in delaying implementation to give providers additional time to meet the requirements.** However, with Phase 3 implementation currently scheduled for November 2019, we are concerned the proposal may not be finalized in time to have any meaningful impact. This has caused uncertainty among LTCFs, with many reporting they feel the need to move forward with compliance in November 2019 as planned. **It is critical CMS provide an update to LTCFs as quickly as possible so they have a clear timeline and know their responsibilities to meet Phase 3 deadlines and requirements.**

OTHER RECOMMENDATIONS

We urge CMS to work with Congress to enact a federal definition of long-term care pharmacy

Premier believes long-term care pharmacies (LTCPs) play a critical role in the delivery of quality care across the continuum. For example, LTCPs importantly help reduce medication-related errors in LTCFs and provide enhanced services that improve quality of care, such as 24/7 drug delivery and drug utilization review. Unfortunately, despite the important role of LTCPs, there is no statutory definition of the term "long-term care pharmacy" in federal law. In recent years, this has led to federal agencies putting forth conflicting and differing interpretations and definitions that, if enacted, would increase regulatory, financial, and operational burden for LTCPs and LTCFs alike. **We urge CMS to work with Congress to adopt a clear definition of long-term care pharmacy to protect beneficiaries from the consequences presented by conflicting definitions.**

We urge CMS to explore approaches to incentivize the adoption of EHRs across the continuum

Premier has previously offered comments to CMS about data and interoperability standards and expressed our concerns about the lack of incentives for post-acute care (PAC) providers to implement health information technology. **We again urge CMS to explore approaches to incentivize the adoption of electronic health records (EHRs) across the care continuum and develop future measures and standardized patient assessment data elements (SPADEs) that use data that are available within EHRs used by PAC providers.**

CMS needs to incentivize PAC, behavioral health (BH), and home and community-based services (HCBS) providers to more readily adopt health IT in support of wider efforts to standardize patient data, improve care quality and reduce costs. To provide these incentives, the Center for Medicare & Medicaid Innovation (CMMI) should develop a pilot program to provide a prospective payment for PAC, BH, and HCBS investment in health IT resources to advance interoperability. CMS has previously structured a similar prospective payment to "improve system linkages" for prescription drug plans (PDPs) in the CMMI Enhanced Medication Therapy Management demonstration model that began in 2017. The demonstration should support investment in health IT, while evaluating outcomes through measurement of interoperability and patient outcomes.

Adoption occurring in non-acute care settings is often supported by partnering health systems that were both eligible for HIT adoption incentives and subject to penalties under the meaningful use – now Promoting Interoperability – program. CMS currently provides Stark Law and Anti-kickback statute waivers to support these efforts for providers' participation in CMMI programs. These waivers should be further expanded

beyond the Medicare Shared Savings Program and CMMI initiatives to permit collaborative investments by health systems and physician groups into interoperable EHR systems in PAC, BH, and HCBS settings.

Measuring interoperability across settings will provide valuable insight into providers' ability to share information that supports care coordination. CMS should focus on developing cross-continuum standards, rather than extending the collection of standards developed for siloed settings of care to additional providers. The IMPACT Act mandated the establishment of standardized patient assessment data elements across PAC settings. However, this assessment is still effectively siloed since it applies only to PAC. Extending these data collection requirements to hospitals and physicians represents a workaround to interoperability that does not consider how care is provided across settings.

A holistic approach is needed for data standards whereby standards are developed for use across care settings, though provider types vary in the level of acuity and types of conditions they are clinically appropriate to serve. There are at present a limited number of common data elements across inpatient, outpatient, and PAC care; however, these elements could serve as a starting point for cross-continuum patient assessment. For example, medication reconciliation is currently collected in the inpatient setting and has been included in the IMPACT Act-mandated PAC assessment. Interoperable sharing of medication reconciliation information is particularly relevant to improving care coordination and preventing adverse drug reactions. Developing data standards that consider how medication reconciliation occurs in various settings and what information is shared across settings will enhance interoperability in this area. As the proposed US Core Data for Interoperability (USCDI) and data standards are developed, adopted and implemented, CMS and the Office of the National Coordinator should consider how data will be collected and exchanged across care settings.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the *Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions To Promote Efficiency, and Transparency* proposed rule. 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 212-901-1264.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier