PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 1, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1779-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 2024 [Docket Number: CMS-1779-P*]*

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) 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 2024 (CMS-1779-P)"* proposed rule which was published in the April 10, 2023 *Federal Register*.

In our detailed comments below, Premier urges CMS to:

- Focus on additional efforts to advance interoperability by developing standards and measures for data exchange and sharing across all care settings, including skilled nursing facilities (SNFs), via electronic data exchange;
- Explore policy options to incentivize SNFs to adopt electronic clinical surveillance technology to reduce and prevent healthcare associated infections (HAIs);
- Consider the burden associated with COVID-19 vaccination measures, especially in light of CMS revoking COVID-19 vaccination mandates for healthcare workers.
- Move forward with a health equity adjustment (HEA) to the SNF Value Based Purchasing (VBP) program while continuing to test, refine and advance additional measures that produce a valid HEA for the VBP;
- Field a request for information (RFI) to solicit stakeholder feedback on the potential development of a program to enable the provision of SNF services in the home; and
- Analyze the impact of waiving the SNF 3-day stay requirement during the public health emergency (PHE) versus its reimplementation post-PHE, focused on cost and patient outcomes, to inform policymaking on the future of this requirement.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 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, 812 million hospital outpatient and clinic encounters, and 131 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).

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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

In the proposed rule, CMS describes ongoing efforts by the U.S. Department of Health and Human Services (HHS) to encourage and support the adoption of interoperable health information technology (IT). These initiatives are designed to advance nationwide health information exchange to improve healthcare and patient access to their digital 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, 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 is 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 and expedite 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 adopt health IT more readily 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, Premier believes 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, Premier believes SNFs would benefit by implementing clinical surveillance systems that would allow them to:

- Discontinue medications where there is a drug-bug mismatch or where unnecessary;
- Prevent adverse drug events;
- Switch from intravenous medications to less expensive oral formulas;
- Eliminate redundant antimicrobials;

[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 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-19, outbreaks of additional pathogens such as Clostridioides difficile or methicillin-resistant Staphylococcus aureus (MRSA), 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 Modification of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure

CMS proposes to modify the HCP COVID–19 Vaccine measure to replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition. CMS also proposes to update the numerator to specify the time frames within which HCP is considered up to date with recommended COVID–19 vaccines, including booster doses, beginning with the FY 2025 SNF QRP.

Premier is generally supportive of aligning with the Center for Disease Control and Prevention's (CDC) definition of "up-to-date," however Premier is concerned this change will impose significant burden on SNFs and that publicly reporting this data may have limited value to the public given the lag in reporting and the end of the public health emergency (PHE). The proposed changes to the measure will require SNFs to track CDC guidance on a quarterly basis and will also require SNFs to change their processes to track whether HCP have received multiple doses. If CDC were to update their guidance and require additional boosters, SNFs would then need to validate whether all HCP met the new requirements. This will create an added burden for SNFs to adapt to the new recommendations that will take both time and staff resources. If CMS moves forward with the measure as proposed, ***Premier believes it is critical that SNFs are afforded sufficient time for reporting in each instance where the CDC recommendations change.***

Further, ***Premier continues to urge CMS to expand the criteria of HCP that are exempted beyond those with contraindications as defined by the CDC.*** There are numerous reasons beyond health contraindications that HCP may decide whether to be up to date with CDC recommendations. Over the course of the PHE, there have been many changes in COVID-19 vaccine availability and evolving CDC recommendations, contributing to wide variation in rates of vaccination among HCP. Further, rates of vaccination among HCP are largely dependent on factors outside a SNF's control, such as where the facility is located and personal preference of the facility's staff. 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. Taken together, these factors confound the Vaccine Coverage Among HCP measure capturing SNF quality.

With the end of the PHE on May 11, 2023, CMS has rolled back numerous requirements that were in place to tackle the COVID-19 pandemic, including a federal mandate requiring the vaccination of healthcare personnel.[3] In the SNF proposed rule, CMS notes the efficacy of vaccines in preventing the worst consequences of COVID-19 and that it believes the measure will continue to provide valuable information to patients and their caregivers, even with the end of the PHE. Premier is comfortable with continuing reporting on this measure for 2024 as the Administration and the broader healthcare ecosystem continue to assess what COVID-19 looks like moving forward and the need for ongoing vaccinations and boosters. However, Premier encourages CMS to continue to evaluate and revisit the measure requirements and the utility of this measure for patients and facilities as part of

[3] https://public-inspection.federalregister.gov/2023-11449.pdf

next year's rulemaking. ***At a minimum, Premier urges CMS to revise the measure to only require annual reporting, which would align with reporting requirements for the influenza measure*.**

Proposed Adoption of the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure

In the rule, CMS proposes to adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure into the QRP beginning with the FY 2026. The proposed measure is a process measure that reports the percent of stays in which residents in a SNF are up to date on their COVID–19 vaccinations per the CDC's latest guidance.

Consistent with our recommendations regarding the HCP COVID Vaccination measure, ***Premier is generally supportive of aligning with the CDC's definition of "up-to-date," however Premier is concerned this change will impose significant burden on SNFs***. The proposed changes to the measure will require SNFs to track CDC guidance on a quarterly basis and will also require SNFs to change their processes to track whether patients/residents have received multiple doses. If CDC were to update their guidance and require additional boosters, SNFs would then need to validate whether all patients/residents met the new requirements. This will create an added burden for SNFs to adapt to the new recommendations that will take both time and staff resources. If CMS moves forward with the measure as proposed, ***Premier believes it is critical that SNFs are afforded sufficient time for reporting in each instance where the CDC recommendations change.***

Premier also is concerned that the proposed measure for patients/residents may not accurately measure SNF quality, as patient vaccination may be driven by factors that are outside the SNF's control. Further, Premier is also concerned about the implications of the measure 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 CDC recommendations, knowing that this may result in the SNF receiving a low-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 a COVID-19 vaccination to bring them in line with CDC recommendations during their short stay, even when vaccine administration may increase the risk of adverse health outcomes. Lastly, we note the MAP Coordinating Committee reached 90 percent consensus on its recommendation of "do not support with potential for mitigation" when evaluating this proposed measure. For these reasons, ***Premier urges CMS to <u>not</u> adopt COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure.***

Public Reporting of the Transfer of Health Information to the Provider—Post-Acute Care Measure and Transfer of Health Information to the Patient—Post-Acute Care Measure

CMS proposes to begin publicly displaying data for the measures: (1) Transfer of Health (TOH) Information to the Provider—Post-Acute Care (PAC) Measure (TOH-Provider); and (2) TOH Information to the Patient—PAC Measure (TOH-Patient) beginning with the October 2025 Care Compare refresh or as soon as technically feasible. These measures are the percentage of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider and/or to the patient/family/caregiver at discharge or transfer. With these measures, SNFs are incentivized to maintain strong communication between the long-term care pharmacy, the SNF care team, and residents and their families/caregivers. In prior comments, Premier supported the adoption of these measures because we believe the transfer of a reconciled medication list is critical to ensuring consistent care when a patient changes settings. ***Premier supports the public reporting of these measures to provide the public with this key piece of information regarding SNF quality.***

IV. SNF VALUE-BASED PURCHASING (VBP) PROGRAM

Proposal to Incorporate Health Equity into the SNF VBP Program Scoring Methodology

Beginning with the FY 2027 program year, CMS proposes to implement a Health Equity Adjustment (HEA) in the SNF VBP to be calculated using a methodology that considers both the SNF's performance on the SNF VBP Program measures, and the proportion of residents with Dual Eligibility Status (DES) out of the total resident population in a given program year at each SNF. To be eligible to receive HEA bonus points, a SNF's performance would need to meet or exceed a certain threshold and its resident population during the applicable performance period for the program year would have to include at least 20 percent of residents with DES. Thus, SNFs that perform well on quality measures and serve a higher proportion of SNF residents with DES would receive a larger adjustment. ***Premier supports CMS' efforts to implement a VBP payment adjustment to reward SNFs that can 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 HEA for the VBP.***

Proposal to Increase the Payback Percentage to Support the HEA

In conjunction with the HEA methodology, CMS proposes to increase the total amount available for a fiscal year to fund the value-based incentive payment amounts beginning with the FY 2027 program year. Under the proposed variable payback percentage methodology, CMS estimates the payback percentage for FY 2027 program year will be 66 percent, compared to the current 60 percent. While Premier applauds CMS for proposing to increase the payback percentage from 60 percent to 66 percent, ***Premier strongly encourages CMS to finalize an HEA methodology that will result in a 70 percent payback percentage each year*** – the maximum authorized in statute under section 1888(h)(5)(C)(ii)(III) of the Social Security Act. This will provide additional incentives to high performing SNFs and accelerate CMS' efforts to advance health equity.

Health Equity Approaches Under Consideration for Future Program Years: Request for Information (RFI)

CMS seeks comments on possible health equity advancement approaches to incorporate into the SNF VBP in future program years that could supplement the proposed HEA, including social risk indicators – such as geographic indicators – that would be most appropriate for assessing disparities and measuring improvements in health equity. CMS specifically references the Area Deprivation Index (ADI) as an indicator it could consider for the program.

Premier has some general reservations about the use of an area-related index as well as the ADI itself. Specifically, ***Premier is concerned that an area-related index does not capture patient-specific situations, and thus its use as a proxy may not fully identify undeserved beneficiaries to whom hospitals are providing care***. For example, if a patient had their own socioeconomic crisis in a more well-to-do area, it would not be identified through application of an area-related index. In fact, a similar limitation was recently identified in a Health Affairs article focused on the ADI,[4] which noted that high home values can mask high deprivation in other social risk factors.

Given that the SNF VBP Program distributes a fixed pool of incentive payments, it is critical that CMS ensures the methodology for calculating this bonus accurately captures a SNF's underserved population. CMS should consider the following challenges associated with calculating social risk indices:

- *Account for redundant social risk variables.* Many of the variables used within social risk indices, such as the ADI, are highly correlated even across domains (e.g., housing and transportation, minority status, socio-economic status, etc.). This can lead to overstating certain aspects of social risk within the composite index. There are certain statistical techniques that can help account for these redundancies and ensure the variables are not double counted and ultimately improve the accuracy and fairness of the index, as was recently highlighted in a journal article utilizing Premier data.[5]

[4] "ACO Benchmarks Based On Area Deprivation Index Mask Inequities", *Health Affairs Forefront*, February 17, 2023, https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities
[5] Korvink, Michael et al, "A Novel Approach to Developing Disease and

- *Ensure variables are weighted appropriately.* The second challenge is that current social risk indices are equally weighted, regardless of the disease group being evaluated. Social risk has varying degrees of association with adverse events (e.g., mortality, readmissions, and complications) in the context of certain disease groups. As a result, it is important to weight the aspects of social risk that are most closely associated with the outcome of interest within a certain disease state. For example, researchers have found that THA/TKA mortality is much less sensitive to social risk indices than pneumonia mortality.[6] Furthermore, within pneumonia mortality, certain aspects of social risk are more important than others. As a result, it is critical when developing social risk indices to consider the disease group being evaluated.

Therefore, Premier urges CMS to provide SNFs with additional information on how they would perform on the HEA through confidential reports and allow additional opportunity for stakeholders to provide input on any adjustments to the methodology prior to adoption.

V. PROVISION OF SNF-LEVEL CARE IN THE HOME

According to the 2020 Census, from 2010 to 2020 the 65-plus population experienced its largest-ever 10-year numeric gain.[7] As the U.S. confronts an aging population, an increasing number of seniors are likely to need skilled nursing care. At the same time, the country is confronting a decrease in the number of skilled nursing facility beds available; a recent study found that the number of nursing home beds in the U.S. fell by almost 25 percent from 2011 to 2019 relative to the number of older adults.[8] Furthermore, labor challenges continue to plague SNFs as 87% of nursing homes report facing moderate or high staffing shortages.[9]

Addressing the gap between the need for and availability of skilled nursing beds will require innovative thinking. One potential approach is to facilitate the provision of skilled nursing care in patients' homes, similar to how acute care hospital at home was enabled by CMS during the COVID-19 PHE to address limited hospital bed capacity in the face of the pandemic. This approach would allow skilled nursing providers to maintain patients' access to services despite bed limitations, while also acknowledging the increasing interest of patients in staying in their homes and communities to receive needed care. However, such an approach likely would require regulatory flexibility, as well as stable and adequate payment. ***Premier urges CMS to field a RFI to solicit stakeholder feedback on the potential development of a program to enable the provision of SNF services in the home.*** Areas for feedback should include regulatory flexibilities necessary to operationalize such a program; methodologies to ensure adequate reimbursement; appropriate measurement of the quality of care provided in the home; and health equity considerations.

VI. EVALUATION OF SNF 3-DAY RULE REQUIREMENT

Medicare currently requires a medically necessary inpatient hospital stay of at least three consecutive days for the program to pay for SNF services. While providers have long pushed to permanently eliminate the requirement, policymakers have indicated concerns about the potential to increase Medicare spending and negatively impact patient outcomes. However, limited waiver of the requirement has been tested in certain

Outcome-Specific Social Risk Indices," *American Journal of Preventive Medicine,* May 3, 2023, https://www.ajpmonline.org/article/S0749-3797(23)00203-9/fulltext
[6] Ibid.
[7] "U.S. Older Population Grew From 2010 to 2020 at Fastest Rate Since 1880 to 1890," U.S. Census Bureau, May 25, 2023, 2020 Census: 1 in 6 People in the United States Were 65 and Over
[8] "A Worrying Drop in the Availability of Nursing Home Beds," Weiss, Madison, April 25, 2023, A Worrying Drop in Nursing Home Beds - Penn LDI (upenn.edu)
[9] https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/SNF-Survey-June2022.pdf

accountable care organization (ACO) and bundled payment programs (e.g. the Medicare Shared Savings Program (MSSP), the Bundled Payments for Care Improvement Advanced program).

Additionally, the requirement was broadly waived during the PHE to address limitations on hospital bed capacity, and this waiver became very important to many providers during the pandemic. In a survey of Premier hospitals and non-acute providers conducted before the end of the PHE, [10] the SNF 3-day stay waiver was among the top waivers identified by respondents as integral to their operations and critical in the event of future pandemics.

Recent research on impact of the waivers of the 3-day stay requirement have found no evidence that waiving the requirement increases Medicare costs. One recent study on use of the COVID-19 PHE waiver between March 2000 – September 2021 found that while the waiver was associated with a marked increase in the prevalence of SNF episodes without a preceding hospitalization, overall SNF care costs did not increase substantially.[11] A CMS Innovation Center analysis on the use of the SNF waiver among ACOs similarly found no evidence that Medicare costs increased as a result of the waiver. Further, beneficiaries under the ACO waivers had shorter SNF lengths of stay and were more likely to be discharged home. Additionally, adverse outcome rates for waiver stays were lower than or similar to those for 3-day non-waiver stays.[12]

While these studies provide a glimpse into the potential implications of eliminating the 3-day stay requirement, the widespread use of the waiver throughout the COVID-19 PHE provides a rich data source for more robust analysis and consideration regarding whether the waiver should be made permanent. ***Premier urges CMS to undertake an analysis of the impact of waiving the SNF 3-day stay requirement during the PHE versus its reimplementation post-PHE, focused on cost and patient outcomes, to inform policymaking on the future of this requirement.*** CMS should share the results of this analysis with Congress for consideration as a permanent waiver.

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 2024 (CMS-1779-P)"* proposed rule. Premier looks forward to working with CMS and other stakeholders to develop reforms that strengthen our nation's SNFs and care for vulnerable populations.

If you have any questions regarding our comments or need more information, please do not hesitate to contact me at Soumi_Saha@premierinc.com or 732-266-5472.

Sincerely,

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

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[10] https://premierinc.com/newsroom/blog/the-end-is-near-are-providers-ready-for-the-unwinding-of-the-covid-19-public-health-emergency

[11] "Medicare Skilled Nursing Facility Use and Spending Before and After Introduction of the Public Health Emergency Waiver During the COVID-19 Pandemic," Agne Ulyte, MD, PhD, et al; *JAMA Internal Medicine*, April 24, 2023, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2804301

[12] Skilled Nursing Facility 3-day Waiver: Use in ACOs 2014 to 2019 (cms.gov)