PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 18, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1718-P
Submitted electronically to: http://www.regulations.gov

Re: CMS-1718-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 2020

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 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 2020*." The proposed rule would update the Medicare payment rates and the quality programs for skilled nursing facilities (SNFs).

Premier supports CMS' efforts to implement the SNF Patient Driven Payment Model, while improving the SNF Quality Reporting Program (QRP) and Value-Based Purchasing Program. Premier appreciates CMS' intent to advance policies to improve the medication therapy received by SNF residents and offers comments on several elements of the proposed rule. We also offer recommendations about interoperability across the care continuum as it relates to proposed quality measures**.**

TRANSFER OF HEALTH INFORMATION

CMS proposes the addition of two new process measures for the SNF QRP beginning with fiscal year (FY) 2022 for a new quality domain entitled Transfer of Health Information: 1) Transfer of Health Information to the Provider – Post-Acute Care (PAC) and 2) Transfer of Health Information to the Patient— PAC. CMS notes that both proposed measures support their meaningful measures priority of promoting effective communication and coordination of care, specifically the transfer of health information and interoperability.

Premier supports CMS' proposals to ensure the transfer of health information to other providers and to the patient; however, CMS can help make this process more efficient and accurate by focusing on additional efforts to advance interoperability across the care continuum via electronic data exchange.

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The IMPACT Act of 2014 requires the Secretary to 1) implement specified clinical assessment domains using standardized (i.e. uniform) data elements; 2) develop and implement quality measures using standardized assessment data; and 3) develop processes for data reporting. Using standardized quality measures and standardized data will help enable interoperability and access to longitudinal information to facilitate coordinated care, improved outcomes, and overall quality comparisons.

Ensuring interoperability across electronic health records (EHR) systems and settings of care can unlock barriers to data sharing and care coordination between health systems, physician group practices, independent physicians, and 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 post-acute care. The transfer of information between SNFs and other providers most often occurs via cumbersome and resource-intensive manual processes. CMS needs to consider ways to incentivize SNF and other 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.

Transfer of Health Information to the Provider – Post-Acute Care (PAC)

The proposed process-based measure of Transfer of Health Information to the Provider–Post-Acute Care (PAC) assesses whether a current reconciled medication list is given to the subsequent provider when a patient is discharged or transferred to a subsequent provider setting. The proposed measure is calculated as the proportion of resident stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at the time of discharge.

Premier strongly supports CMS efforts to improve data exchange and interoperability between care settings. We support the measure at discharge because it will improve the exchange of patient specific information about medications between a SNF and other PAC providers. This will help ensure continuity of drug therapy, which is critical for patients during transitions. This measure will contribute to improved health outcomes and help reduce avoidable hospital readmissions.

Transfer of Health Information to the Patient – Post Acute Care (PAC)

The proposed Transfer of Health Information to the Patient–Post-Acute Care measure assesses whether a current reconciled medication list was provided to the patient, family, or caregiver when the patient is discharged from a PAC setting to a private home/apartment, a board and care home, assisted living, a group home, transitional living or home under care of an organized home health service organization, or a hospice.

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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

Premier applauds CMS for proposing that a SNF furnish medication reconciliation information to either the patient, family member, or caregiver when a patient is discharged. We believe that providing medication reconciliation information to the patient, family, or caregiver at discharge from a SNF will help improve patient compliance with medication therapy once the patient leaves a SNF. This flexibility is essential because it allows the SNF to determine the most appropriate individual to provide this critical information to during a care transition. For example, SNF residents may have a cognitive impairment, making the family member or caregiver the best option to understand the information and to follow-up as appropriate.

While we support the concept of both proposed Transfer of Health Information measures, Premier cautions about the additional administrative burdens and challenges they will place on SNFs and other PAC providers. As already noted, most PAC providers do not have access to EHRs or health information technology systems that facilitate their ability to electronically share (send and receive) this information. PAC settings, unlike acute and ambulatory care settings, were not included in CMS' meaningful use program and therefore do not have mechanisms in place to incentivize the use of electronic health records. Therefore, many do not currently have the digital tools necessary to allow for the efficient and appropriate transfer of electronic health information. We encourage CMS, as it considers more measures around the transfer of health information, to ensure the standards incorporate the PAC setting. We further urge CMS to work with ONC to ensure that the US Core Data for Interoperability (USCDI) includes data classes and elements relevant to SNFs and other PAC providers. Furthermore, we urge CMS to work with ONC to:

- Leverage ongoing efforts to adopt data standards and implementation guides for certified EHRs (such as the USCDI); and
- Build on efforts to base measures and calculations (numerators/denominators) on data within certified EHRs.

Additionally, while the dichotomous yes/no approach for medication reconciliation is an important next step, Premier encourages CMS to continue to refine the measures to ensure a quality medication reconciliation is performed. Consideration for future measures could capture quality metrics, such as the accuracy of the medication reconciliation and the extent to which the reconciliation influenced the care when the patient moves to a new setting. As CMS continues to refine these measures, Premier encourages CMS to pursue moving from process-based measures towards outcome-based measures to better understand how the transfer of a medication reconciliation list at discharge impacts patient outcomes.

REPORTING FOR HIGH RISK DRUG CLASSES

CMS proposes a series of Standardized Patient Assessment Data Elements (SPADEs) reporting, including a new data element assessing at admission and discharge whether the resident is taking any medications in six specific drug classes, and if so, whether there is an indication noted for all the medications in the drug class.

Premier strongly supports CMS' efforts to ensure SNF residents are protected from unintended consequences that may occur with the use of high-risk medications. We support the inclusion of the six drug classes identified by CMS in the proposed rule: antipsychotics, anticoagulants, antibiotics, opioids, antiplatelets, and hypoglycemics (including insulin). Premier also agrees that an indication for use should be documented for medications prescribed to SNF residents. Additionally, Premier urges CMS to align measures for high risk drugs across other programs, including Medicare Part D and the Inpatient Prospective Payment System. Consistent measurement will provide for comparable assessment across the continuum of care. The measure proposes to capture those high-risk drugs that include a documented indication for use, which may be helpful in assessing quality of care. Additionally, we urge CMS to ensure

the collection (or any future public display) of facility-specific data does not convey that quality of care is diminished by the mere presence of more high-risk drugs. A wide array of factors could lead to greater use of high-risk drugs, such as medical necessity. CMS should proceed cautiously to not compare facilities on the singular data element of the presence of high-risk drugs.

SNF QRP QUALITY MEASURES, MEASURE CONCEPTS, AND STANDARDIZED PATIENT ASSESSMENT DATA ELEMENTS UNDER CONSIDERATION FOR FUTURE YEARS: REQUEST FOR INFORMATION

CMS solicits a Request for Information seeking input on the importance, relevance, appropriateness, and applicability of measures, SPADEs and concepts for future years in the SNF QRP.

Premier has previously offered comments to CMS about data and interoperability standards and expressed our concerns about the lack of incentives for PAC providers to implement health information technology. We again urge CMS to explore approaches to incentivize the adoption of EHRs across the care continuum and develop future measures and 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.

PUBLIC DISPLAY OF MEASURE DATA FOR THE SNF QRP

CMS proposes to add the SNF QRP measure "Drug Regimen Review Conducted with Follow Up for Identified Issues" to the Nursing Home Compare website. The data display would begin with 2020 or as soon as technically feasible and would be for a rolling four quarters of data, initially using data for discharges occurring during calendar year 2019. Data for SNFs with fewer than 20 eligible cases in any four consecutive rolling quarters would not be publicly displayed. For those SNFs, the website would indicate that the number of cases is too small to publicly report.

Premier supports inclusion of the measure "Drug Regimen Review Conducted with Follow Up for Identified Issues" to the Nursing Home Compare website. Drug Regimen Review (DRR) is an essential service, and under current regulations for long-term care facilities (including SNFs), "the pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon."[3] Beyond the long standing DRR requirement in SNFs, we believe the public display of this measure may spur the SNF, medical director, attending physician, director of nursing and consultant pharmacist to continuously evaluate and improve their communication processes for DRR follow up. Further, Premier supports the proposed policy regarding reporting for SNFs with fewer than 20 eligible cases in any four consecutive rolling quarters.

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 2020* 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@innovatix.com or 212-901-1264.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance

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[3] *CMS Memo Ref: S&C 17-07-NH: Advance Copy – Revisions to State Operations Manual (SOM), Appendix PP- Revised Regulations and Tags, 11/09/16. F428, §483.45(c) Drug Regimen Review. Page 566. Accessed at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf*