Illinois Health and Hospital Association

June 7, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: FFY 2022 Skilled Nursing Facility PPS Proposed Rule (CMS-1746-P)

Dear Ms. Brooks-LaSure:

On behalf of our 18 member hospitals providing skilled nursing facility services, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the federal fiscal year (FFY) 2022 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) proposed rule. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis in the development of this rule, particularly the attention paid to addressing the ongoing COVID-19 pandemic and its impact on the SNF quality reporting program (QRP) while simultaneously moving the industry toward complete digitization of Medicare quality programs and seamless electronic data exchange.

Given all of the challenges and opportunities in front of the healthcare industry, we request that CMS consider the following recommendations:

- Pursue a combined delay and phased approach to recouping overpayments attributed to an inaccurate parity adjustment to PDPM Case Mix Indexes;
- Continue to pursue National Quality Forum (NQF) endorsement of all proposed and considered QRP measures, including the proposed COVID-19 Vaccination among Health Care Personnel (HCP) measure;
- Monitor revised SNF QRP reporting periods that rely on fewer quarters of data until normal reporting processes resume to ensure data reportability and reliability;
- Ensure adequate time and resources for post-acute care (PAC) providers, including SNFs, to transition to electronic standards such as Fast Healthcare Interoperability Resource (FHIR); and
- Explore options to revise the SNF VBP 60% payback requirement to 100% under future extraordinary circumstances the require measure suppression.

Recalibrating the Patient-Driven Payment Model (PDPM) Parity Adjustment

In the FFY 2020 SNF PPS final rule, CMS finalized an adjustment factor of 1.46 and applied this adjustment to PDPM case mix indexes (CMI) so that total estimated

payments under PDPM would be equal to total actual payments under Resource Utilization Groups, Version IV (RUG-IV). Upon reviewing FFY 2020 data, CMS found that it might have inadvertently triggered a 5% increase in overall payment levels under the SNF PPS with this adjustment, failing to achieve budget neutrality when transitioning to PDPM.

IHA agrees that the data in proposed rule Table 23 suggest that changes in average therapy CMI appear to be due to the transition to PDPM rather than the COVID-19 public health emergency (PHE). Additionally, we agree with CMS' rational for modifying the methodology used to calculate the parity adjustment, as reclassifying SNF patients under the RUG-IV using FFY 2020 data would not be accurate. Finally, we agree with CMS' decision to exclude patients diagnosed with COVID-19 and patients whose stays utilized a PHE-related waiver from the calculated increase in aggregate spending.

Regarding CMS' request for comments on how to recoup these overpayments, IHA urges the administration to avoid immediate recoupment of the 5% overpayment. Many SNFs are currently repaying COVID-19 Advance Payments. Such facilities will see 25% of their Medicare payments automatically recouped for the next 11 months, with an increase to 50% for 6 months after that. Recouping additional amounts on top of the COVID-19 Advance Payments may significantly affect cash flow for some SNFs. Therefore, IHA requests CMS consider a combined approach of delay and phase-in to recoup these parity adjustment overpayments. While we agree establishing an accurate baseline is important, the extraordinary circumstances presented by COVID-19 warrant a recoupment delay.

COVID-19 Vaccination among HCP Measure

IHA appreciates the process CMS went through to assure the validity of the proposed COVID-19 Vaccination among HCP measure. Illinois hospitals look forward to full U.S. Food & Drug Administration (FDA) approval of the various COVID-19 vaccinations on the market, and IHA urges CMS to continue pursuing full NQF endorsement of the COVID-19 Vaccination among HCP measure in the coming months. While CMS has the authority to include measures in the SNF QRP that are not NQF-endorsed, securing NQF endorsement is typically required when creating and implementing measures for the Medicare QRPs. We believe NQF endorsement of this measure is especially important because we agree with CMS that patients, particularly those most vulnerable to COVID-19, will consider the vaccination rate among HCP when deciding where to pursue medical services in the future. Providing such information through an NQF-endorsed measure affords patients greater certainty that the information they rely on is fully vetted and reliable.

SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization Measure

Similar to the proposed COVID-19 vaccination measure, IHA appreciates the process CMS went through to develop the proposed new quality measure, SNF HAIs Requiring Hospitalization, beginning with the FFY 2023 SNF QRP. IHA agrees it is important to document and track HAIs. Further, we recognize emerging evidence associating high SNF HAI rates in pre-pandemic years with poor patient COVID-19 screenings and higher patient COVID-19 spread in FFY 2020.

Additionally, IHA agrees that the healthcare system must act to address the inequities laid bare by the disproportionate impact COVID-19 had and continues to have on historically underserved communities. We appreciate that CMS believes this proposed measure may support overall HAI prevention and control in SNFs, particularly for patients of color and other underserved populations.

As with the COVID-19 vaccination measure, IHA urges CMS to complete plans to submit the measure for NQF endorsement. Ideally, CMS would wait to implement this measure until NQF endorsement is secured, particularly because there are NQF-endorsed measures available to serve as interim proxies for an overall HAI rate (e.g., Percent of Residents with a Urinary Tract Infection (Long-Stay) (NQF #0684), National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infections (NQF #0138), NHSN Central Line-Associated Bloodstream Infections (NQF #0139), and NHSN Facility-Wide Inpatient Hospital-onset Clostridium Difficile Infection (NQF #1717)). Again, NQF endorsement is the gold standard in quality measure development and utilization, and we support CMS in holding itself to this standard when possible.

Transfer of Health Information to the Patient Post-Acute Care (TOH-Patient)

IHA supports CMS' proposal to remove patients discharged to the home under the care of a home health agency or hospice from the TOH-Patient measure. We appreciate CMS' continued review of measures used in its various Medicare QRPs to make changes that mitigate unnecessary provider burden.

Public Reporting of SNF QRP Measures Impacted by COVID-19 Exemptions

On behalf of Illinois hospitals and health systems, IHA thanks CMS for the temporary quality reporting exemptions granted to providers for Q4 2019, Q1 2020 and Q2 2020. We also agree with CMS' decision to freeze the data displayed on Care Compare with the October 2020 refresh values until the agency determines a way to adjust public data for the PHE and exempted reporting quarters in publicly displayed data.

As explained in the proposed rule, CMS' COVID-19 Affected Reporting (CAR) Scenario to progress with Care Compare refreshes in December 2021 appears adequate in ensuring data reportability and reliability. IHA requests that CMS continue to monitor modified Care Compare refreshes until normal reporting resumes to ensure the CAR approach produces valid and reliable results.

Definition of Digital Quality Measures and Request for Information on Fast Healthcare Interoperability Resource (FHIR)

IHA appreciates CMS' tireless work to improve its quality programs and move toward more meaningful quality measurement. In this proposed rule, CMS requested feedback on the following definition of Digital Quality Measures (dQMs):

dQMs are quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. A dQM includes a

calculation that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources.

This proposed definition includes a long list of potential sources of digital data, and does not appear tailored to the post-acute care (PAC) environment. While we appreciate the Meaningful Measures 2.0 initiative is meant to innovate and modernize quality measurement across a wide variety of settings, we question whether such a broad definition allows CMS to utilize only the most valuable and impactful quality measures. We also question how this definition improves upon today's quality reporting program, beyond the fact that measures will be digital.

With regard to use of FHIR-based standards in the PAC setting, IHA generally agrees that electronic exchange of clinical information may lead to improved health and quality outcomes. However, fully moving to dQMs by 2025 is an ambitious goal, particularly because the adoption of health information technology is not uniform across provider settings. Many PAC providers lagged behind their acute care hospital counterparts on the path toward digitization even before the COVID-19 pandemic, primarily because PAC providers could not participate in the Electronic Health Record (EHR) incentive program established under the HITECH Act. As PAC providers build back from the COVID-19 PHE, they will need increased time and resources to move toward CMS' goal of a fully digital electronic health information system. To that end, we ask CMS to reconsider its timeline, and the monetary and technical assistance available, for providers to adopt the technologies necessary to realize the goals of the Meaningful Measures 2.0 initiative, including FHIR-based standards.

Finally, Illinois hospitals and health systems have expressed difficulties with the myriad standards and formats used by various stakeholders to electronically capture and exchange information. As CMS pursues enhanced digitization and interoperability, IHA urges CMS to work with others to ensure consistency in formatting and process standards across providers, vendors and payers. This will lesson provider burden and better equip the healthcare industry to realize improved communications and health outcomes.

SNF Value-Based Purchasing (VBP) Program

IHA appreciates CMS' proposed Measure Suppression Factors developed in response to the COVID-19 PHE. We agree that measure data significantly impacted by the PHE should not adversely affect provider payments. And while IHA recognizes that some SNFs performed well on the Skilled Nursing Facility 30-Day All-Cause Readmission measure (SNFRM) (NQF #2510) regardless of the COVID-19 PHE, we believe CMS proposed a fair path forward given the FFY 2020 average reliability estimate for this measure is lower than the generally accepted minimum reliability threshold (0.367 and 0.40 respectively). Therefore, we agree with CMS' proposal to suppress SNFRM from the FFY 2022 SNF VBP program year (the program year utilizing FFY 2020 data).

Ideally, given the PHE, SNFs would receive the entirety of the VBP withhold amount for FFY 2022 SNF VBP program year. However, IHA recognizes that CMS is statutorily bound to redistribute only between 50% and 70% of the total amount withheld for the VBP. Further, IHA understands that in the 2018 IPF PPS final rule CMS determined it would use 60% of payments withheld to fund VBP value-based incentive payments. However, in that same rule CMS stated it would closely monitor the effects of the payback percentage policy on participating SNFs. At the time, CMS did not anticipate a pandemic, nor did it consider other scenarios under which it might want to hold participating SNFs harmless. In light of the COVID-19 pandemic, we strongly urge CMS to reevaluate its SNF VBP payback policy, particularly for unique situations that might require measure suppression. At a minimum, we believe CMS should consider maximizing the payback percentage to the 70% allowed under statute in such cases where they want to hold participating SNFs harmless. Additionally, we encourage CMS to revisit the SNF VBP with Congress and consider modifications to statutory language for such situations where the administration would want to hold participating SNFs harmless. As it stands, all SNFs are coming out net negative in the FFY 2022 SNF VBP program year through no fault of their own.

IHA also applauds CMS' consistent reevaluation of Medicare QRPs in an effort to enhance their impact and effectiveness. IHA appreciates that many of the quality measures under consideration for future SNF VBP program years (Table 31 of the proposed rule) align with other PAC QRPs, resulting in a more aligned approach to quality measurement across provider settings. As with other QRP measures, IHA believes it is important for CMS to seek NQF measure endorsement even if they are able to forgo such endorsement per appropriate exceptions. IHA urges CMS to pursue NQF endorsement for all measures before including them in future QRP program years. We will closely examine proposed SNF VBP measures with our members as CMS proceeds through this process.

Ms. Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule. Please direct questions or comments to IHA.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association