National Association for the Support of Long Term Care

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National Association for the Support of Long Term Care

June 7, 2021

Mrs. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

VIA Electronic Submission

Re: File Code CMS-1746-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 2022

Dear Administrator Brooks-LaSure:

The National Association for the Support of Long-Term Care (NASL) is a membership organization representing suppliers of ancillary services and providers to the long term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies that employ physical therapists, occupational therapists, and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in nursing facilities as well as to beneficiaries in other long-term and post-acute care settings. NASL members also include both vendors of health information technology (IT) that develop and distribute clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers of assisted living as well as skilled nursing and ancillary services. In addition, NASL members include providers of clinical laboratory services, portable x-ray/EKG, and other specialized supplies for the LTPAC sector. NASL is a founding member of the Long Term and Post-Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which was formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.

NASL is pleased to submit these comments in response to the *Proposed Rule* noted above and published in the Federal Register on April 15, 2021. Our comments are focused on the Patient-Driven Payment Model (PDPM), recommended payment refinements in response to COVID-19, the Skilled Nursing Facility Quality Reporting Program (SNF QRP), the SNF Value-Based Payment (VBP) program, as well as other issues related to the Requests for information regarding Health Equity and Health IT.

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Market Basket Update

In the *Proposed Rule*, CMS has proposed a payment update for FY 2022 at 1.3 percent, reflecting a 2.3 percent market basket increase, less the 0.8 percent forecast error correction, with an additional 0.2 percentage point reduction for the multifactor productivity adjustment. **NASL supports this payment update of 1.3 percent.**

Regarding the proposal to limit adjustments for future forecast error corrections by increasing the threshold for correction from 0.5 percent to 1.0 percent, NASL supports this policy change to provide greater certainty and stability for providers under the SNF PPS.

In the *Proposed Rule*, CMS is seeking to revise and rebase the SNF market basket, updating the base year from 2014 to 2018. While NASL is generally supportive of the update and recognizes that the data for reweighting certain components of the market basket was derived from Medicare Cost Report data, we do wish to convey that labor costs continue to be a challenge for the industry. Providers often have difficulty finding and retaining employees, a well-known challenge for the industry. However, the market basket reduces the labor portion of the formula. While this data may be reflected in the Medicare Cost Reports, it may ignore the need to provide greater funding for SNFs in order to meet the heightened costs of labor, rather than continue on a trajectory of reduced funding and limited ability to increase wages. Additionally, CMS should consider the increased costs of Personal Protective Equipment (PPE) due to the COVID-19 Public Health Emergency (PHE); these increased costs are not reflected in the Medicare Cost Report data from 2018 that was used in the market basket update proposal, yet providers will face these costs throughout the future payment updates based on the revised market basket. CMS should consider ways to account for the increased PPE costs for providers, which are likely to continue even as the Public Health Emergency wanes.

Patient Driven Payment Model (PDPM) Parity Adjustment

Prior to COVID-19, October 1, 2019, marked the implementation of the Patient Driven Payment Model (PDPM) for case-mix adjustment under the SNF PPS. Implementing PDPM has been a multifaceted effort – including understanding the new model and then educating providers on the new parameters for payment and schedules for assessment while health IT vendors had to program the new system and test their software. NASL members worked diligently to understand the new system and then to train staff on assessing patients under PDPM in order to be ready for an implementation on October 1, 2019. Thankfully, providers had some initial time after October 1st under PDPM to adjust and become familiar with the new payment model before COVID-19's impact at the beginning of 2020. The Public Health Emergency (PHE) was declared on January 31, 2020 (with a start date of January 27, 2020), and the onset of the pandemic severely disrupted normal operations.

The COVID-19 pandemic has had a devastating effect on patients and caregivers and has upended the provision of care in nursing facilities. Almost all aspects of patient care including rehabilitation therapy and the provision of services such as x-rays at the bedside and lab services have been significantly impacted.

In an effort to limit the spread of COVID-19, the CDC's guidance encouraged nursing facilities to limit staff from entering the facility on a daily basis and severely limit staff entering multiple facilities. NASL members including rehab therapists, x-ray technicians and lab technicians faced significant issues accessing their patients in nursing facilities. Rehab therapists frequently treat or see patients in multiple nursing facilities in a single day. Portable x-ray and clinical lab service providers respond on a daily and hourly basis to physician orders for these services and so need to enter multiple nursing facilities each day. Limiting the staff that could enter nursing facilities was a necessary policy, yet it made it difficult to continue patient access to many of these services and has increased costs.

Rehab therapists worked very hard under very difficult conditions to continue their patient's access to medically necessary rehab therapy. NASL members have reported that in some buildings there were limitations to such an extent that only a physical therapist could treat patients on one particular floor while an occupational therapist could treat patients on an alternative floor. Wings or floors or zones of a building that had been designated for COVID-19 patients dictated where therapists could and could NOT be within the facility. They found ways to provide therapy in patient's rooms because therapy gyms were closed because of social distancing requirements.

Unfortunately, therapists and other providers were exposed to COVID-19 despite precautions (PPE was severely limited in the early months) and they needed to quarantine for 14 days as a precaution from exposure. We have heard many stories of rehab therapists desiring to continue to work during their quarantine and utilizing telehealth technology to treat once CMS authorized it in May of 2020. Because movement by clinicians and other staff in the nursing facility could be limited because of varying COVID status of patients, therapists pitched in to help with duties normally conducted by others. Therapists helped pass trays to assist with feeding residents, they helped the nursing team and they helped to electronically connect residents to their families using devices and tablets. Their dedication to their patients despite the conditions is both gratifying and commendable.

Furthermore, the kind of patients entering SNFs changed – through a waiver of the 3-day stay requirement, some patients came to the SNF sooner after an acute care episode in a hospital. Depending on the state and ability of the facility to handle COVID-19 patients, some SNFs received many COVID-19 patients, while others did not receive as many. Additionally, the rapid collapse in elective surgical procedures, especially for orthopedic conditions, meant that those patients were suddenly not coming to SNFs because they were not having procedures. Other patients made decisions about whether they wanted to seek care at home or in a SNF, decisions not based on their medical need but on the fear of the unknown from COVID-19. This was especially true early in the pandemic when the effects of COVID-19 on one's long-term health were not yet known. In sum, just as providers were more comfortable adapting to PDPM, the PHE disrupted the norm and continues to create significant disruption. We are now 8 months into the second fiscal year of PDPM and the pandemic continues, and we are still under a PHE. As a result, we lack a full year of "unaffected" data under PDPM, with only data from an implementation period from October 1, 2019, to the start of the PHE on January 27, 2020. **We**

do not believe CMS should make decisions to reduce reimbursement based on less than a year of data that was also the initial implementation period for a new payment model and rolled into a year that includes a world-wide pandemic that impacted the most vulnerable residents of nursing facilities. We recommend that CMS accumulate and assess a year of data that is untainted by the COVID-19 PHE. NASL recommends an additional year without this past year's extraordinary circumstances, so that statistically valid conclusions based on an "apples-to-apples" comparison can be made.

With these factors in mind, we understand that CMS made efforts to review the initial data from PDPM to understand changes in patient care and cost. While we appreciate CMS taking steps to try and modify the patient cases being reviewed to make it look more like what a "typical" year of patients would look like, the situation under the PHE has been anything but normal. Even when removing patients with diagnoses for COVID-19 or who entered a SNF under a waiver of the three-day stay requirement, the subset of "regular" patients was anything but regular and regardless of if there was an outbreak or not, CDC and CMS guidelines and requirements still applied. The patients had different conditions than normal, owing to the missing patients from elective procedures, and other patients may not have had a COVID-19 diagnosis accurately reflected in their chart. Testing was not available in the early months and so it was very difficult to conclusively diagnose COVID-19. There were also significant limitations in how care could be provided to patients, especially for rehab therapy. While telehealth helped bridge the gap that was required by social distancing and infection control, the PHE put significant strains on the ability of providers to provide care, and for patients to be able to receive therapy care.

In short, while CMS found a 5% overpayment for patients under PDPM compared to RUG-IV, we believe that despite CMS' best efforts to isolate COVID-19 patient data from the rest of the data, facility's operations were so impacted by changing clinical and reporting requirements and waivers that COVID had more of a far-reaching impact then that can be ascertained in the data. CMS should consider the significant challenges of the past year that may not be readily identifiable in the patient data.

Providers of care under the SNF PPS faced significantly higher costs than normal during the COVID-19 PHE, such as for ongoing COVID-19 testing and PPE needs. While the SNF PPS is set up to pay an appropriate amount during "normal" times, what providers and their patients have faced during the PHE has been anything but normal. In addition, costs to contracted therapy providers for PPE was not included in payments for PDPM. CMS should consider the significantly higher costs of safely providing quality care as it considers whether an overpayment has occurred.

In recognition that the data from the implementation of PDPM was disrupted by the PHE, CMS should wait until it has a "clean" period of data to consider adjustments and consider delaying any reduction until more data is obtained. NASL recommends it would be appropriate to consider a "clean" period of data beginning no less than 60 days after the end of the PHE and continuing for one full Fiscal Year after that.

NASL appreciates CMS sharing the initial data it observed during the start of PDPM around minutes for the provision of therapy. In discussing this issue with our members, who include therapy providers working for SNFs, we believe there are a variety of reasons for the variation in therapy minutes that were observed. We hope that CMS will recognize that providers sought to make changes in anticipation of adapting to a new assessment and reimbursement system, while always prioritizing patient care and quality. Additionally, the start of allowing greater use of group and concurrent therapy changed how some patients received appropriate care; as providers worked to establish appropriate care groups and workflows, certainly adjustments in the provision of therapy were made and reevaluated.

In the *Proposed Rule*, CMS reports that the percentage of stays where patients received any amount of group therapy was 29% and any amount of concurrent was 32% at the beginning of PDPM. This also means that more than 68% of patients received individual therapy as a part of their care plan. This metric should not be interpreted that the provision of group and concurrent therapy exceeded CMS's limit of 25%. NASL members report that group and concurrent therapy were within CMS's mandated limits. CMS notes that these percentages dropped—as we would expect—in April 2020 when the pandemic was raging. CMS also notes that despite the changes in therapy provision, they did not identify any significant changes in health outcomes for SNF patients.

With respect to the data point presented in the *Proposed Rule*, CMS states the average provision of therapy minutes per patient per day for fiscal year 2019 was approximately 91 minutes. CMS states that at the time of PDPM this changed to approximately 62, a 32% drop. NASL member data does not show such a precipitous drop. We believe there would be some reduction in therapy minutes as SNF providers shifted to PDPM. We ask CMS for more clarity around the methodology for this metric to help us understand what is behind this number so that we can further compare this with the experience in the field.

While we do not believe a parity reduction is warranted, we recommend that CMS consider data from a full year without a public health emergency before far reaching financial reductions are made. If CMS does implement a reduction, it should be delayed at least one year and should be phased in over a multiyear period to ensure financial stability for facilities, especially as they continue to experience lower census counts for patients.

<u>SNF Quality Reporting Program (QRP)</u>

In recognition of the challenges the COVID-19 PHE has presented to providers and the patients they serve, NASL appreciates that CMS has taken various steps throughout the SNF Quality Reporting Program (QRP) to recognize the disrupted nature of data collected during the COVID-19 PHE. While CMS specifically proposes policies to exclude data from Q1 and Q2 2020, NASL notes that the effects of the pandemic still continue today, far beyond Q2 2020, and that as CMS considers using data beyond Q2 2020, there should be recognition that the effects of the pandemic have continued.

For the FY 2023 SNF QRP, CMS is proposing to adopt two new measures, on Healthcare-Associated Infections (HAI) Requiring Hospitalization and COVID-19 Vaccination Coverage among Healthcare Personnel.

With regard to the measure on HAI Requiring Hospitalization, NASL wishes to underscore that the pandemic period has produced abnormal experiences for patients due to ongoing challenges with limiting patient exposure to health care providers (as part of limiting COVID-19 infection risk) and other challenges of patient isolation. As CMS considers using data for this measure, there should be recognition that COVID-19 has presented challenges and that pre-pandemic data may differ from data gathered throughout the full duration of the pandemic. Further, this measure draws from data prior to institution of the required infection control specialist in facilities.

On the measure for COVID-19 Vaccination Coverage among Healthcare Personnel, NASL appreciates the prioritization of nursing home patients and personnel during the initial rollout of the vaccine and notes the robust success in vaccinating seniors, which has dramatically curtailed cases in this population. The vaccination of health care workers has also protected the providers who care for these patients and given peace of mind that they may not be risking bringing COVID-19 home to their families, children, and other loved ones. NASL understands that this information is important for both CMS' oversight efforts as well as for families and patients making choices about care. While we have seen varying rates of uptake for the vaccine among healthcare personnel, education about benefits of the vaccine continues.

Since the release of the *Proposed Rule,* CMS issued an Interim Final Rule with Comment that contained similar reporting requirements for vaccination information of health care personnel. NASL requests that CMS provide further information on how reporting to a system maintained by the Centers for Disease Control and Prevention (CDC) will be shared with CMS for purposes of recognizing the reporting of data in compliance with the requirements of the SNF QRP (in reference to penalties for SNFs who do not report their data as required under the SNF QRP). We also question how reporting under the NHSN, which is not done using the MDS, will be handled under the SNF QRP as it regards penalty for non-reporting? While measuring vaccination rates for healthcare personnel is a very important metric and one, we support, NASL requests that CMS reconsider including this measure under the SNF QRP because it is already measured by CDC and shared with CMS.

Finally, CMS requests information on SNF QRP quality measures under consideration for future years. The measures under consideration include frailty, patient reported outcomes, shared decision-making process, appropriate pain assessment and pain management processes, and health equity.

As a broad comment on all of these measures under consideration for future years, NASL asks that CMS consider the provider burden of collecting this information and the "how, when, and where" of collecting this information. If this information is to be collected through the MDS, that adds additional time to the MDS assessment. If this information is to be collected through a patient survey provided to the patient during their time in the facility, this requires hardware

(tablets for example, which facilities may not have, and may have concerns with passing around to patients amid concerns with reducing infections), and for some patients with vision, hearing, or cognitive impairments, may require assistance in completing a survey. While NASL supports the goals and intentions of gathering further information to improve the quality of care, NASL hopes CMS considers the practical concerns of gathering this information.

On the potential for a measure on patient reported outcomes, NASL encourages CMS to consider what burden the collection of this information may put on patients and providers. Specifically for patients, there is significant resistance to filling out additional paperwork, especially if it takes the form of a survey mailed to patients after their stay, when they are home and if they are still continuing their recovery. NASL encourages measures such as this to be patient-focused, not program management-focused. NASL also asks that providers not be penalized for actions beyond their control – for example, making providers responsible for whether patients fill out a survey is challenging for providers, as providers have no control over whether a patient fills out a survey they received in the mail.

NASL wishes to remind CMS, as we commented in 2019 when the standardized patient assessment measures were developed, that the Beta Study (contracted to RAND) they were based on did not appear to include speakers of limited English proficiency nor were non-English instructions included for those administering the assessment. We remain concerned that the Beta Study results may have omitted a significant segment of the Medicare beneficiary population who reside in culturally diverse areas and are not fully proficient with the English language. This has significant implications for some of the measures being considered for the future including patient reported outcomes, shared decision-making process, appropriate pain assessment and pain management processes, and health equity.

With regard to equity, as CMS considers ways to gather data on health care equity, NASL asks CMS to provide detailed information on where this data would be drawn from. For example, adding this information to the MDS may require additional staff time. However, other ways to gather the data (such as from other electronic health record sources) may be more feasible in gathering the information in a way that does not create additional burden.

Finally, on the potential inclusion of a measure on appropriate pain assessment and pain management processes, NASL supports efforts to ensure the appropriate use of pain management techniques and treatments, especially in light of the challenges presented by the risk of opioid addiction. NASL's therapists have the skills and education to offer non-pharmacological interventions to reduce pain, and any measure on this issue should recognize the opportunity for care to be a part of the pain management process.

Related to digital Quality Measures (dQMs) in general, NASL supports this idea with further comments later in this letter. (See section on RFI). However, in addition to the above noted burden on providers to move toward collection of data to meet dQMs, we also encourage recognition of the additional cost on our IT vendor members to develop these new data collection items into the electronic health record (EHR). Further, any new items like this require additional burden on providers to train staff on how to collect and enter this data. From this perspective,

collection of new data for dQMs are, essentially, unfunded mandates. As a reminder, long term care did not receive any monies under HITECH for IT infrastructure and yet, in order to collect the data needed for dQMS, nursing facilities must be using an EHR. This provider burden could be minimized by incentivizing SNFs to move toward full electronic data collection.

SNF Value-Based Purchasing (VBP) Program

In response to the disruption caused by the COVID-19 PHE and its impact on the data underpinning the quality measure for the SNF VBP program, the *Proposed Rule* seeks to assign all SNFs a single value for their performance score for the performance period of the FY 2022 SNF VBP Program. While we appreciate CMS taking steps to recognize the impact the PHE has had on patients and providers, we have concerns with CMS assigning a performance score that essentially results in a penalty by having a 1.2 percent payback (below the 2 percent withhold) for all providers (except for low-volume facilities, which would receive the full 2 percent payback). Given the hardship COVID-19 has caused to patients and their health care providers, we encourage CMS to explore options for providing SNFs their full 2 percent withhold amount.

NASL supports establishing a measure suppression policy for SNF VBP during the current PHE for COVID-19, as well as future national PHEs. We believe that the four proposed Measure Suppression Factors are appropriate and comprehensive. NASL also appreciates CMS' intent to standardize the policy across settings and payment programs, to include the Hospital VBP Program.

The Consolidated Appropriations Act, 2021, included a provision permitting the Secretary of the Department of Health and Human Services (HHS) to add up to an additional nine measures to the SNF VBP, for a total of up to ten measures. CMS includes in Table 31 a list of quality measures under consideration.

NASL believes that if additional measures are to be added to the SNF VBP, they should only include National Quality Forum (NQF) endorsed measures. Furthermore, if additional measures are to be included, CMS should explain how they will be weighted, if at all, against other measures in the SNF VBP Program, or if a single composite score will be developed and used for measuring performance.

Overall, NASL believes that adding nine additional measures to the SNF VBP Program will be too aggressive in expanding the measures used in the program; however, thoughtfully adding a smaller number of measures would be easier to integrate into the program. Providers are experiencing measure fatigue and continuing to add additional measures may not allow providers to focus appropriately. NASL recommends that CMS reassess measures that may no longer be necessary and if measures are added at all, it should only be two or three measures; we recommend including:

- NQF 3481, Discharge to Community Measure-Post Acute Care Skilled Nursing Facility Quality Reporting Program

- NQF A2636, Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

If a PROMIS measure is proposed, we recommend it be reviewed by NQF first. We also remind CMS that we believe the PROMIS measures were not developed for the institutional population. Again, we remind CMS of the additional unfunded nature of this burden on providers and IT vendors to collect, store and transmit this data.

Additionally, CMS is seeking comment on whether the measures in an expanded SNF VBP measure set should require SNFs to collect data on all residents in the facility, regardless of payer. While NASL recognizes the value in collecting data from a wide range of patients, we want to emphasize that certain payers, primarily those under the Medicare Advantage program, have set limits and policies for SNF care, including significantly limiting the number of days far below what patients receive under Medicare Part A. If CMS includes data from all payers and uses this data as part of the SNF VBP, CMS needs to recognize that providers are constrained in their ability to help patients reach their maximum potential improvement outcome, because certain payers, such as Medicare Advantage, push for patients to be discharged quickly, even if a provider such as a therapist believes further rehabilitation therapy would produce further improvement.

Requests for Information (RFI)

Request for Information on the Use of FHIR Standards and digital Quality Measures (dQM)

NASL recognizes that CMS has included identical Requests for Information (RFIs) in the annual payment rules for various care settings, including Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs). Because NASL member companies operate in, and support providers in each of these care settings, our comments may apply to all of these settings. However, we are responding to the specific proposals contained in the *FY2022 Skilled Nursing Facility Prospective Payment System (SNF PPS) Proposed Rule*.

First, NASL appreciates CMS' intent "to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange." We also welcome the acknowledgement by CMS that streamlining data collection, calculation and reporting can leverage clinical and patient-centered health information to improve measurement and care quality.

While the RFI captures a few of CMS' activities to support its goal of moving to digital quality measurement by 2025, it appears that this RFI represents the first time that CMS has announced this very ambitious goal in the course of regular rulemaking. NASL and its members are familiar with a variety of initiatives that CMS identified as supporting this laudable, albeit audacious, goal. For example, we have tracked CMS' Meaningful Measures Framework and been involved with the implementation of CMS' Internet Quality Improvement & Evaluation System (iQIES) for data collection and maintenance. We also applaud the agency's work with

healthcare standards organizations in order to ensure emerging and evolving electronic health information standards will support CMS' assessment instrument content.

NASL generally supports the move to digital quality measurement (dQM) and a streamlined approach to data collection, calculation, and reporting. We recognize the advantages of having a streamlined, digital system that allows information to be shared across settings; however, there are significant practical challenges to securely collecting and storing the data needed for these dQMs, which is why we caution CMS to avoid establishing unfunded requirements around collecting, recording and sharing this information.

Clearly, there are strides to be made as CMS builds a system that can utilize dQMs. We applaud CMS' setting of "stretch" goals; however, any expectation of implementing such a system across the care continuum by 2025 seems unrealistic. Doing so would require more than just an aggressive timeline given the state of health information technology (health IT) adoption and use in the long term and post-acute care sector, especially as we remain under a National Public Health Emergency (PHE).

We look forward to a future time when quality measures are captured and shared electronically. More importantly, we also welcome the development of truly meaningful measures that can inform clinicians' decision making with and for the care of our Nation's most vulnerable population – older and underserved Americans with multiple comorbidities who are cared for in Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long Term Care Hospitals (LTCHs) and their homes and communities. Unfortunately, we believe that there is a wide chasm between where we are now and that future state.

NASL and its members have been active participants in the Post-Acute Care Interoperability (PACIO) Project since its inception. NASL and our members have gathered with other stakeholders and federal contractors working with CMS and the Office of the National Coordinator for Health Information Technology (ONC). Together, we have worked diligently on a nearly weekly basis since February 2019. We are proud of our collective work to develop Fast Healthcare Interoperability Resources (FHIR) Implementation Guides (IGs) for the exchange of health data on both functional and cognitive status as well as the development of a new use case around speech language pathology. We are told by veterans of Health Level 7's (HL7's) standards development process that our work to produce the two IGs and additional use cases is considered "rapid" progress. Even with the support of both CMS and ONC, and the guidance of a devoted group of federal contractors and committed stakeholders, it took two years to produce two IGs.

We also recognize the painstaking work that went into CMS' development of process measures as required by the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.* This October will mark seven years since the *IMPACT Act* became law and nearly a full decade will have passed by the time the last of the six *IMPACT Act* measures are implemented. **NASL is drawing on our experience with implementing the *IMPACT Act* as well as our work as**

part of PACIO when we caution CMS regarding its exceptionally aggressive timeline for developing dQMs.

NASL appreciates CMS' acknowledgement that dQMs will require alignment of measures, concepts and specifications (to include narrative statements, measure logic, value sets, etc.). **NASL seeks clarification from CMS regarding the process for aligning and harmonizing measures (outside of measures developed as a part of the *IMPACT Act*) across care settings.**

There is a tremendous amount of data standardization that needs to occur in advance of implementing a system for digital quality measurement. Because data standardization is supremely foundational to accessing data from various sources, **NASL recommends that CMS focus its efforts on ensuring that the systems and resources needed are in place before attempting to implement an entire system for digital quality measurement.**

We recognize that some of the foundational components for an "interoperable" system are not within CMS' purview. CMS should work with ONC and stakeholders like NASL to ensure that the critical clinical data – such as the data elements currently included in the US Core for Data Interoperability (USCDI) – are well defined and captured in a standard way across the care continuum. Without some measure of semantic interoperability, the exchange of this health information is likely to fall short of CMS' expectations and limit our ability to improve care.

In addition to prioritizing standardization of critical clinical data needed for provider-to-provider exchange (*e.g.,* USCDI) and care transitions, **NASL recommends that CMS explore a phased-in approach to implementation.** LTPAC and other providers who CMS deemed ineligible for previous federal incentive funds should be allowed more time to implement future measures than their incentivized colleagues who work in acute and ambulatory care settings that have benefitted from federal health IT incentive programs.

NASL appreciates CMS acknowledging that incentives are important to reward innovative uses of health IT. Regardless of incentive, this RFI outlines a vision that we believe is predicated on foundational items that have yet to materialize. Moreover, CMS' vision for a system of digital quality measurement – a vision that we embrace – will take a massive amount of work. To be clear, this is collaborative work across care settings, which is both expensive and complex.

We also believe that there are other foundational pieces needed to do this kind of work. There is no mention of how CMS might address cyber security issues, which is troubling as we continue to learn more about cyber threats to our Nation's critical infrastructure. Nor is there any reference to important real-world considerations such as how data exchange may be tested before implementation. CMS has done little to encourage or incentivize ways for the LTPAC sector to address these challenging and complex issues. **NASL seeks clarification from CMS as to its consideration of these issues as well as the fundamental question that LTPAC providers will ask – how am I going to do all of this and pay for it?**

Clearly, the ONC can help to address some of the questions that we have raised. NASL and our

members have been working on standards identified by ONC for the better part of the last decade even though there is no federal requirement or true business case to compel these health IT development companies to do so. Our members are part of Carequality, CommonWell and work with a variety of health information exchanges across the country. We also eagerly anticipate more progress around implementation of the Trusted Exchange Framework & Common Agreement (TEFCA). Even if the software vendor has the capability to work with an HIE, the cost to each SNF provider for initial setup fees and ongoing maintenance with skilled IT support is often too expensive without some sort of incentive by CMS. CMS has laid out no plans to help encourage long term care providers to adopt electronic exchange of data, which would be the only way that CMS could collect dQMs from SNFs. Providers that simply do not have the margin to invest heavily in electronic exchange will be left behind, once again, which we know has implications for health equity when facilities cannot participate in quality improvement initiatives because they cannot meet expectations for electronic exchange through no fault of their own.

NASL and our members have been integral to the collective progress that we celebrate to date. We welcome the opportunity to work with CMS in collaborating with the health IT developers who support long term and post-acute care providers. Understanding which data points are needed, and where and how data points are collected and shared are essential if we expect to have health IT that can support good clinical decision making about the care and services an individual need.

NASL is eager to achieve many of the health IT milestones that will be needed to implement CMS' vision. Even so, we implore CMS to consider that we remain under a national PHE and that recovery from the COVID-19 pandemic is ongoing. NASL members already are working with CMS and its contractors on upgrading to iQIES and we look forward to addressing prior authorization and ways to achieve a more responsive system for public health reporting. We ask that CMS consider how all of these competing priorities must be managed at an operational level as well as CMS' role as part of the Nation's critical infrastructure in further exploring plans for achieving CMS' overall vision.

RFI on Health Equity

NASL appreciates the Biden Administration and the efforts of CMS in particular to address the significant and persistent health inequities in skilled nursing facilities. Far too many elderly Americans do not have the health literacy, formal education, technical tools or physical wherewithal to allow them adequate access to exercise those care choices to improve their health.

We appreciate that CMS has identified the Standardized Patient Assessment Data Elements (SPADEs), which include some of the social determinants of health (SDOH), as a potential starting point for the collection of key SDOH data. Before using the SPADEs or any SDOH data as part of a quality measure formula for its Quality Reporting Programs, however, NASL recommends that CMS evaluate what SDOH data elements are well-defined and ready for data

collection. HL7's Gravity Project has done considerable work on SDOH around food insecurity and transportation, which may provide critical insights to improve discharge planning for underserved populations. In addition to health information technology standards for SDOH, CMS might evaluate data collected by Medicare Advantage plans to see if it aligns with important SDOH data. NASL recommends that CMS review the work of the Gravity Project and similar initiatives working on SDOH. In addition, CMS should consult clinicians who understand how SDOH data elements impact an individual's health as part of an evaluation of the specific types of data that should be collected in order to inform and advance CMS' efforts to address health disparities.

As an example, expanding the minimum list of race and ethnicity categories as defined by the U.S. Office of Management & Budget (OMB) in the Minimum Data Set 3.0 (MDS 3.0) is an important step; however, even the broader list does not reflect all of the cultural sensitivities that may be needed to improve health inequities. NASL further recommends that CMS share its evaluation of SDOH data with stakeholders as part of a process for developing meaningful measures that can be used across CMS' quality reporting programs. By working with health IT standards organizations, clinicians and other stakeholders, we believe that CMS will be more successful in developing measures that allow for SDOH data to become actionable in terms of improving treatment plans and functional outcomes.

Ensuring that there is alignment in terms of what data is being collected across the care continuum and that the data collected is standardized are critical to CMS' efforts to close the health equity gap. Likewise, defining and collecting such data in a standardized way are equally important. NASL recommends that CMS consider using the USCDI ONC New Data Element & Class (ONDEC) Submission System to facilitate alignment of this SDOH data.

CMS' emphasis on health equity and the use of standardized data, data collection and reporting presuppose that all providers have access to electronic health records (EHRs), health IT systems and sufficient Internet connectivity to support the data collection, submission and data sharing envisioned by CMS. Unfortunately, adoption and use of health IT in the long term and post-acute care sector still lags behind that of hospitals and physician offices that benefitted from the substantial federal investment in health IT incentives such as CMS' Promoting Interoperability Incentive Programs. Overcoming that imbalance in our nation's healthcare system and health IT infrastructure must be part of the federal government's – and CMS' efforts in particular – to address health inequities.

If we are to succeed in closing the gap in health equity, it will require sustained effort over time NASL welcomes the opportunity to contribute what and where we can to narrow and close the health equity gap.

Conclusion

On behalf of the members of NASL, I thank you for the opportunity to provide these comments. Please do not hesitate to be in contact should more information or detail be needed. If you have any questions regarding our comments, please contact cynthia@nasl.org or 202-213-0289.

Sincerely,

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