



June 17, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

SUBJECT: CMS-1710-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2020; Proposed Rule, Federal Register (Vol. 84, No.79), April 24, 2019

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, including approximately 80 inpatient rehabilitation facilities (IRFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) IRF prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2020.

CHA supports and appreciates CMS' proposals to:

- Incorporate two years of data into the revised case-mix data to be implemented for FFY 2020.
- Clarify language about qualifications for rehabilitation physician medical directors.
- Change the specifications for the IRF Quality Reporting Program (QRP) measure "Discharge to Community – PAC."

CHA does not oppose CMS' proposal to eliminate the one-year lag in wage index data used to adjust the IRF PPS. However, CHA strongly opposes the use of the current FFY 2020 wage index data that was released as a public use file on April 30 due to the exclusion of 7 hospitals in California.

Specific to CMS' proposals for data collection resulting from implementation of standardized patient assessment data elements (SPADEs), CHA urges CMS to:

1. **Reduce the speed and scope of SPADE implementation.** Absent a more gradual, considered timeline for implementation, IRFs are forced to continuously add new elements and processes to ones that already exist, without time to assess and test a re-designed workflow process that could more efficiently and effectively meet the goals of an accurate assessment and inter-setting communication.
2. **Create and make transparent a data use strategy and analysis plan** for the SPADE items so that post-acute care providers, including IRFs, better understand how the agency will further assess SPADEs' adequacy and usability in the development of a unified PPS and future quality measures.
3. **Develop a framework in the IRF Patient Assessment Instrument (PAI) for prioritizing implementation of the critical SPADEs to go forward October 1, 2020.** In addition, the agency should strongly consider a period of voluntary reporting for a number of SPADEs to better understand their value in future data use strategies.

4. **Detail and adopt a staged implementation plan** to allow IRFs and other post-acute care providers additional time to manage the operational and workflow changes needed to ensure reliable and valid data collection across all patients. Additional evaluation of SPADEs and their intended uses are needed prior to nationwide implementation and adoption.

CHA strongly supports the goals of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 and appreciates CMS' ongoing efforts to improve payment accuracy, including aligning reimbursement more closely with patient characteristics and aligning patient assessment items across care settings. However, the scope of these changes and their timing remain problematic.

As detailed below, the cumulative effect of the proposed case-mix changes, the significant addition of SPADEs, and the unintended consequences of a flawed area wage index policy for FFY 2020 present operational challenges to IRFs — particularly those in California, where the impact of the change in area wage index policy is significant. The unprecedented change occurring in the post-acute care setting will require additional staff training and present untold operational challenges. Simultaneous implementation of policy changes of this magnitude to one payment system on the timeline proposed will not only undermine the agency's long-term policy goals, but will also impose significant hardship on IRF providers. Rethinking this implementation — and staging it appropriately — will benefit both providers and CMS in the long term.

CMS' APPROACH TO PPS CHANGES FOR POST-ACUTE CARE PROVIDERS

CHA shares CMS' goals of ensuring that patients receive post-acute medical and rehabilitative care in the setting most appropriate for their needs, and that patient assessment practices support effective care treatment plans and transitions. We also recognize CMS' continued work toward its long-term goal of a unified post-acute care payment system.

In the past 18 months alone, significant changes have been proposed and implemented in each post-acute care payment system. **We urge the agency to develop additional lines of communication with stakeholders, such as a:**

- **Multi-disciplinary stakeholder workgroup**, representing all post-acute settings, to advise CMS on the strategic and operational implications that should be considered as these concurrent changes go forward. We recommend specific emphasis of the SPADEs implementation across settings. Convening the full continuum of providers offers an opportunity for shared learning and understanding and allows for discussion of a common analysis framework — while still allowing CMS to engage in a dialogue about the impact on patient care. Such a group (or groups) would help the agency in meeting its long-term goals of a unified post-acute care PPS, as stakeholder engagement conducted only in payment silos is counter-intuitive. While we appreciate the stakeholder engagement to date, formalization of a working group representing post-acute care settings would promote shared dialogue between stakeholders, rather than only between individual stakeholders and CMS.
- **Data analytics advisory group** to assist CMS and its contractors in establishing a framework for SPADE analysis and ongoing assessment.

CHANGES TO THE IRF PPS CASE-MIX SYSTEM FOR FFY 2020

Effective October 2019, CMS will determine patients' case-mix group (CMG) using data items collected on admission and recorded in Section GG of the IRF-PAI into the CMG classification system, rather than

on the FIM™ instrument; FIM™ will be eliminated entirely from the IRF-PAI. In association with this change, CMS will update the functional status scores used in the case-mix system, revise the CMGs, and update the relative weights and average length of stay values associated with the revised CMGs.

IRFs are currently required to complete the IRF-PAI upon admission and discharge of each Medicare Part A fee-for-service patient and each Medicare Part C (Medicare Advantage) patient. IRF-PAI data are used to classify patients into payment groups based on clinical characteristics and expected resource needs, as well as to monitor the quality of care furnished in IRFs.

CHA recognizes and appreciates CMS' decision to base the implementation of the FFY 2020 revised case-mix classification on two years of data. CHA strongly urges CMS to continue ongoing assessment of the reliability and validity of the data collection efforts and related case-mix changes, including additional provider engagement, education, and training.

Although the functional assessment items in Section GG have been in place since October 2016, we continue to be concerned about the reliability and validity of the reported data that will now be used to determine payment. While Section GG captures many of the same mobility and activities of daily living items as the established FIM™, it uses a significantly different scale, definition, and performance standard. This creates confusion in the field and could undermine data accuracy, secondary to a crossover effect or conflation of the two scales. As IRF clinicians work to ensure they are reporting accurately, our member IRFs note challenges in implementing Section GG, particularly due to evolving interpretations of scoring guidelines. While reliability and validity of the patient assessments will improve over time, the current data are subject to significant variation.

In the FFY 2019 proposed rule, CMS proposed using an unweighted motor score based on data from Sections GG and H of the IRF-PAI for the revised case-mix system. In response to stakeholder comments, CMS now proposes a weighted motor score and provides weights for each of the data elements. CHA commends CMS' responsiveness to provider concerns and appreciates the reported observation that use of the weighted motor score slightly improves the ability of the IRF PPS to predict patient costs. However, we urge CMS to proceed cautiously with this and other changes to the case-mix methodology. As previously stated, we have concerns about the accuracy and consistency of the Section GG data, particularly during the first year of implementation when IRFs were still adjusting to the new scale.

CHA encourages CMS to provide additional comprehensive, accessible, and timely provider guidance and training to support a shared understanding of scoring criteria and assessment procedures. CHA urges CMS to consider providing IRFs with additional information about their reporting in relationship to their peers and national benchmarks, as well as areas of performance improvement. Additionally, CHA strongly urges CMS to closely analyze patient assessment data on an ongoing basis, and reassess and modify case-mix groupings as needed.

AREA WAGE INDEX

For FFY 2020, CMS proposes to change the current wage index methodology to align with the same wage data time frame used by the FFY 2020 inpatient prospective payment system (IPPS). Specifically, CMS proposes to eliminate the current one-year lag in wage index data by using the concurrent fiscal year's pre-rural floor, pre-reclassified IPPS wage index for the IRF PPS wage index. Under this proposal, the FFY 2020 IRF wage index would be based on the FFY 2020 pre-floor, pre-reclassified IPPS hospital

wage index rather than FFY 2019. CMS proposes to implement this proposal in a budget-neutral manner.

CHA does not oppose CMS' proposal to eliminate the one-year lag in wage index data. However, CHA strongly opposes the use of the current FFY 2020 wage index data that was released as a public use file on April 30. As part of the FFY 2020 IPPS proposed rule, CMS verified the Worksheet S-3 wage data by instructing its MACs to revise or verify data elements that result in "specific edits failures." (84 Fed. Reg. at 19375.) CMS excluded 81 providers with "aberrant" data and, most notably, excluded eight (now seven) hospitals that are all part of the same health system. CMS claims this is due to the current private business practice whereby, according to CMS, the health system in recent years negotiated its labor contracts with unions on a regional basis in California and that, as a result, the salaries within each region "are the same regardless of prevailing labor market conditions in the area in which the hospital is located."

CMS states that it proposes to exclude the seven hospitals because it does not believe the average hourly wages of the hospitals accurately reflect the economic conditions in their respective labor market areas (e.g. the core-based statistical areas (CBSAs)). Additionally, CMS asserts that inclusion of these data would distort the comparison of the average hourly wage of each of these hospitals' labor market areas to the national average hourly wage.

CMS argues that, under section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. § 1395ww(d)(3)(E) ("Section 1395ww(d)(3)(E)"))— the statute that requires the Secretary to establish a wage index reflecting the relative hospital wage level in the geographic area of a hospital compared to the national average hospital wage level —it has the discretion to remove hospital data from the wage index that does not reflect the relative hospital wage level in the hospital's geographic area. Although CMS does not say it overtly, it alludes that the seven hospitals' wage data are high compared to their labor market areas. Most concerning, CMS says it is considering removing all 38 hospitals that are part of the health system from the wage index calculations in FFY 2021, "not because they are failing edits due to inaccuracy, but because of the uniqueness of this chain of hospitals, in particular, the fact that the salaries of their employees are not based on local labor market rates." 84 Fed. Reg. at 19376.

The proposed exclusions for FFY 2020 will significantly harm not only IPPS hospitals, but also inpatient psychiatric hospitals (IPFs), skilled-nursing facilities (SNFs), home health agencies, IRFs, and other payment systems that use both the "adjusted and unadjusted" area wage index. It does not appear the Secretary intended such a broad impact, as he failed to even consider other types of providers in his regulatory fiscal impact analysis in the IRF proposed rule, which he is legally required to do. **CHA strongly opposes the exclusion of these hospitals as it will have devastating consequences for IRFs in California.**

We urge CMS to carefully review CHA's FFY 2020 IPPS comments, which outline in detail our concerns and objections to the proposed exclusion of the seven hospitals in the FFY 2020 area wage index public use file. In summary, the exclusion of the seven hospitals would be unlawful for at least five critical reasons:

1. Nothing in the applicable statute, Section 1395ww(d)(3)(E), permits CMS to exclude general acute care hospitals from the wage index data simply because those hospitals' wages are higher

than the wages of other hospitals in their area, or because the hospitals are part of a system that negotiates regional or statewide labor contracts. Rather, as indicated by CMS in past rulemakings, the wages of all short-term acute care hospitals must be included unless such data are incomplete or inaccurate.

2. **Even if CMS had authority to exclude certain hospitals even though their data were accurate and verifiable (as is the case with the seven hospitals), the exclusion of the seven hospitals would be an arbitrary and capricious as CMS has promulgated no standards to govern the exercise of its discretion.** CMS has established an extensive process to ensure the accuracy and reliability of hospital wage data — yet, where it does not like the result, it has decided to deviate from this process by excluding hospitals with accurate data.
3. CMS’ exclusion of the seven hospitals is procedurally improper, as CMS has failed to promulgate a rule in accordance with the APA that would authorize the exclusion of hospitals with aberrant data or to set forth the standards to be applied in determining whether data are aberrant.
4. CMS has failed to consider the relevant factors and has relied on factors that are not relevant under the applicable statute. As a result, its action is arbitrary and capricious.
5. CMS’ basis for excluding the health system hospitals is inconsistent with federal labor law because it interferes with collective bargaining.

Changes resulting from the health system hospital exclusions from the area wage index calculation are untenable and must be reversed in both the IPPS adjusted and unadjusted area wage index.

Moreover, the Secretary has neglected to identify the fiscal impacts on the IRF PPS in CMS’ respective regulatory impact statements. Such failure ignores required duties under Executive Order 12866, Executive Order 13563, section 1102(b) of the Social Security Act, section 202 of the Unfounded Mandated Reform Act of 1995, Executive Order 13132, the Congressional Review Act, and Executive Order 13771. In the IPPS proposed rule — as well as the IRF, SNF, and IPF proposed rules — the Secretary has failed to consider the implication of these exclusions and, as such, has failed to consider the relevant factors, as required under the Administrative Procedures Act.

CHA estimates the exclusion of the seven hospitals in FFY 2020 will have an estimated range of impact on the unadjusted area wage index from negative 3% to negative 10%, as follows:

CBSA #	CBSA Name	Unadjusted AWI WITHOUT Health System (Proposed)	Unadjusted AWI WITH Health System	Impact %
11244	Anaheim-Santa Ana-Irvine, CA	1.1953	1.2338	-3.22%
23420	Fresno, CA	1.0662	1.1477	-7.64%
40140	Riverside-San Bernardino-Ontario, CA	1.1313	1.1903	-5.22%
41740	San Diego-Carlsbad, CA	1.1982	1.2256	-2.29%
44700	Stockton-Lodi, CA	1.3639	1.5012	-10.07%

The estimated costs to California IRFs impacted by this exclusion is approximately \$2.7 million in FFY 2020 IRF payments.

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

CHA supports the currently proposed changes to the IRF Quality Reporting Program (QRP), and recognizes that these changes are part of a multi-year process to reform patient assessment and quality reporting across multiple levels of care.

CMS now proposes to add two new process measures for the IRF QRP beginning with FFY 2022 for a quality measure domain entitled “Transfer of Health Information.” The first proposed measure, “Transfer of Health Information to the Provider – PAC,” would assess whether a current reconciled medication list is given to the subsequent provider when a patient is discharged or transferred from his or her current post-acute care setting. The second proposed measure, “Transfer of Health Information to the Patient – PAC,” would assess whether a current reconciled medication list was provided to the patient, family, or caregiver when a patient was discharged from a post-acute care setting to a private home/apartment, board or care home, assisted living, group home, transitional living, or home under care of a home health service organization or hospice. If finalized, IRFs would be required to submit data on these measures beginning in October 2020.

CMS notes that these two measures have been conditionally supported by the National Quality Forum’s (NQF) Measure Applications Partnership (MAP), pending NQF endorsement.

CHA supports the addition of measures to address the transfer of health information domain, and we recognize that the accurate communication of a current reconciled medication list to PAC providers, as well as patients and caregivers, is critical to a safe and effective care transition. While we remain concerned that these measures still present many implementation challenges, **CHA does not oppose the addition of these measures to the IRF QRP. We urge CMS to pursue the rigorous NQF endorsement process for both of these measures and to continue to make refinements to improve feasibility.**

CHA strongly supports CMS’ proposal to update the specifications for the Discharge to Community PAC IRF QRP measure to exclude baseline nursing facility residents. CMS has found that rates of discharge to community were significantly lower for baseline nursing facility residents compared with non-nursing facility residents. CHA appreciates CMS’ responsiveness to stakeholder comments on this issue.

STANDARDIZED PATIENT ASSESSMENT DATA ELEMENTS

CMS continues implementation of requirements of the Affordable Care Act and the IMPACT Act, including development and implementation of quality measure domains using standardized data elements nested within patient assessment instruments. Similar changes are being implemented in other post-acute levels of care, including long-term care hospitals, SNFs, and home health agencies. The changes provide a basis for CMS’ stated goal of developing SPADEs across all levels of care coordination.

In the FFY 2018 IRF PPS proposed rule, CMS proposed requiring IRFs to report multiple SPADEs, but ultimately finalized only two. Commenters raised a general concern that CMS was moving too quickly and that further testing was needed. Since then, CMS has continued its assessment and evaluation, most notably by conducting a national beta test across the full care continuum, which included several

providers in California. We appreciate CMS' recent efforts to provide additional opportunities for stakeholder communication and input, particularly the stakeholder webinar it held on November 27, 2018, to report on early findings of the test.

Beta Test Results

The beta test presents an important opportunity to test proposed SPADEs in real-world clinical settings and to obtain meaningful input from working clinicians and managers in post-acute care settings. However, the data's value are undermined by shortcomings in the investigation's scope and implementation. These significant limitations underscore the need to proceed carefully and thoughtfully with ongoing SPADE implementation.

While CMS took significant steps to recruit a number of providers and settings in several geographic areas, the number of providers and individuals assessed represents neither the overall IRF patient population nor the patient population of the IRFs in California. For example, in the November 2018 webinar, researchers reported that they had recruited 23 IRFs to participate — just 2% of all IRF providers in the nation. Nearly half of those participants (47.8%) were free-standing, a significant portion of the total (43.4%) were reported to be for profit, and overall, participating IRFs had an average bed size of 285. In California, by contrast, the vast majority of IRFs are distinct-part units of short-term acute care hospitals with fewer than 100 beds.

While all IRFs are subject to the same requirements for medical necessity and patient admission, these organizational distinctions are pertinent to the patient populations served and must be considered when evaluating the results of the data. Compared to large free-standing IRFs, smaller hospital-based units often see patients of greater medical complexity and with a wider range of socioeconomic needs, reflective of the local community. These units do not have the efficiencies of scale seen in larger facilities and are less likely to employ dedicated staff for coding and staff training. The fact that smaller hospital- and community-based IRF units are underrepresented in the current data significantly impacts the results and will result in operational implications.

A similar, even more dramatic shortfall is seen in the number and range of completed patient assessments. CMS reported that 794 IRF assessments were completed — less than 0.2% of total IRF admissions. Moreover, since CMS does not provide information about diagnostic case mix or range of functional impairment, the viewer is unable to determine if this group is representative of the IRF patient population at large or how that selection may have affected the assessment process and results.

For example, CHA member IRFs have expressed grave concerns about the beta test's reported exclusion of patients with communication and cognitive impairments, who comprise a significant portion of IRF admissions and require significantly different — and frequently greater — intervention and resources than a patient with physical deficits only. Assessing patients with communication or cognitive impairments simply takes longer, due to the need to provide necessary accommodations and validate responses. The omission of these patients from the beta test undermines our ability to draw conclusions about the measures' applicability for the broader IRF population, such as how long the proposed assessment measures will take to complete in the clinical setting. Because CMS does not address if/how the measures or their administration can be modified, we question CMS' conclusions about their overall validity and reliability.

Even among IRF patients who are able to participate in the interview questions, many will have mild or moderate deficits in communication or cognition that will affect their ability to respond accurately. Representatives of CMS and the RAND Corporation acknowledged this serious concern in the November 27, 2018, stakeholder call.

Additionally, we understand that the testing did not include non-English speaking patients, who represent a significant portion of the population at many of our member organizations. Nearly 44% of California residents speak a language other than English at home, higher than any other state in the nation. Nearly one in five California residents is considered limited English proficient. Limiting testing to English-speaking individuals only limits our ability to assess the measures' value in a diverse patient population, and brings into question the measures' validity.

It is critical that the next steps in SPADE implementation consider the limitations of the currently available data. **We ask that CMS limit the number and types of SPADEs implemented in the coming year, continue an ongoing dialogue with stakeholders, and develop and implement a process to assess the value of specific indicators for all patient types on an ongoing basis.**

Moreover, CMS should make available the data set that was developed as part of the national beta test. Allowing all parties access will lead to a richer and more informed policy discussion going forward. Releasing the data set would benefit CMS because, through additional third-party analysis, stakeholders will be able to more fully understand the potential impact on their organizations, leading to more informed and robust comments. CHA urges CMS to make the SPADE data set available — and update it as appropriate — so that other external parties and stakeholders may not only replicate CMS' analysis, but also offer additional analysis for consideration.

New Proposed SPADEs

CMS proposes the implementation of several new, non-tested SPADEs and a new assessment domain. The new SPADEs include indicators designed to address use and indications of high-risk drug classes, interference of pain with therapy and activities, as well as several directed at collecting information on social determinants of health.

CHA supports and applauds CMS' recognition of the impact of social determinants of health (SDOH), as well as its efforts to implement a data collection process for social risk factors. We are concerned, however, that CMS proposes to implement untested data elements. The lack of an adequate pilot or trial denies all stakeholders, including CMS, the ability to determine whether the new measures are accurate and valuable or identify the operational implications of their implementation. CMS should first develop a thoughtful data analysis plan, as it has done in other provider settings, which uses a proxy for SDOH to help inform next steps in data collection at the patient level. Assuming applicability and value of the proposed items, without any analytic support — while well intended — is premature.

This critical effort warrants a more thoughtful and considered approach than that of the current proposal. Our shared goals would be more effectively served by reviewing the proposed measures and alternatives, as well as their intended use both short term and long term, and in greater detail prior to required implementation.

Operational Implications

The current proposal represents a significant increase in the data collection and reporting requirements for IRFs. The actual time and cost impact of these new requirements will be considerably higher than CMS estimates.

California post-acute care provider beta-test participants report that the time reported by the contractors to assess patients was not reflective of their experience. Due to the previously discussed limitations in beta test patient sampling, the time and costs associated with administration for the full IRF population is grossly understated. Simply put, it is less time-consuming and less costly to administer these items to a cognitively intact, English-speaking patient with no speech or language deficit than to one with aphasia, attention and memory disorders, or whose primary language is not English. That shortfall, combined with the addition of several new indicators, renders CMS' estimate of the impact on providers' time and resources woefully inadequate.

Recommendations

CHA and its member hospitals, who represent the full range of acute and post-acute care service providers, recognize the importance and value of post-acute care payment reform — including SPADEs. Furthermore, CHA supports CMS' work to more closely align the IRF payment system with patient characteristics and resource needs. On behalf of our member organizations, CHA has been actively engaged in supporting implementation of the IMPACT Act and stands ready to work with CMS as the transformation of PAC services payment and delivery proceeds. We urge the agency to consider the following recommendations.

1. **Reduce the speed and scope of SPADE implementation.** Over the past few years, data collection requirements for IRFs have increased significantly, and members have experienced challenges in developing new procedures for coding, workflow, and documentation. The continuous and rapid pace of additions and changes limit IRFs' ability to make comprehensive changes or to identify the most effective and efficient way to meet new requirements. Absent a more gradual, considered timeline for implementation, IRFs are forced to continuously add new elements and processes to ones that already exist, without time to assess and test a re-designed workflow process that could more efficiently and effectively meet the goals of an accurate assessment and inter-setting communication.

This rapid change also affects the ability of IRFs and their partners to integrate with the electronic medical record. While our hospital members report that they actively collaborate with software vendors and information systems professionals, they note that this iterative process may lag behind the facility's need for actual implementation, so that providers are forced to develop inefficient and duplicative procedures. A more gradual, phased-in approach would enable electronic medical record providers, software vendors, and facilities to develop and test data collection procedures that will stand the test of time and not cause unnecessary expense.

2. **Create and make transparent a data use strategy and analysis plan for the SPADE items so post-acute care providers, including IRFs, better understand how the agency will further assess SPADEs' adequacy and usability in the development of a unified PPS and future quality measures.** Data collection without an understanding of future use or subsequent analysis of

performance based on the intended use is costly to our health care system. Interim alternatives should be strongly considered.

While the beta test was important, more work must be done to ensure that the SPADEs requested on the patient assessment tools can be put to good use in the development of our goals. We urge CMS to engage with stakeholders in detailing how it intends to use these data.

3. **Develop a framework in the IRF PAI for prioritizing implementation of the critical SPADEs. The agency should strongly consider a period of voluntary reporting for a number of SPADEs to better understand their value in future data use strategies.**

A number of SPADE data elements could, as an interim strategy, be collected through claims analysis by the agency. We remain concerned that CMS has not considered any interim strategies to obtain data that are captured and coded to the Medicare claim. With such intense focus on the SPADEs themselves, the idea of collecting similar information in an alternative format to inform the work prior to adding additional items on the IRF PAI has been lost. Before proceeding with full implementation, the agency should explain why certain data elements can **only** be obtained through the IRF PAI and other patient assessment tools, rather than through other means. This would help the agency prioritize and phase in implementation as appropriate.

Allowing voluntary reporting would enable CMS to use participating facilities as valuable “laboratories” for implementation that would provide support and guidance for other IRFs and inform CMS’ future work. It would also allow for the development of technological solutions that could support this process across all levels of care.

For example, several of the proposed elements relate to ongoing treatments or stable conditions that will be documented elsewhere in the patient’s medical record and will not change based on care setting or medical stability. As previously mentioned, some of this data may be obtained through claims analysis. Should that prove to be helpful, imposing a second step of voluntary reporting would allow providers time to work with their electronic health record vendors to develop systems that can populate these elements in the IRF-PAI without requiring additional assessment and documentation by the IRF. Several proposed elements would lend themselves to this approach, including many of the elements in the domain of special treatments and procedures (e.g., dialysis), impairments (e.g., hearing loss), and social determinants of health (e.g., ethnicity).

As previously noted, a large portion of individuals who are admitted to an IRF have a significant cognitive and/or communicative impairment. In fact, in some IRFs these patients would represent the majority of patients served. **CHA recommends that required reporting of certain patient interview items, particularly the proposed items in the domain of cognition and communication, be phased in gradually to allow for additional review of the collected data and the operational impact on IRFs.** An effective process would include active and frequent input from stakeholders, and an iterative process of measure refinement.

As discussed in the November 2018 stakeholder call, a fruitful area of analysis may be the comparison of the results of the beta test items with similar items in the current patient

assessment instruments and other medical documentation. Such a comparison would provide an additional “check” of whether the patient’s response was accurate and reflective of their function and condition outside of the interview process.

4. **Detail and adopt a staged implementation plan to allow IRFs and other post-acute care providers additional time to manage the necessary operational and workflow changes needed to ensure reliable and valid data collection across all patients. Additional evaluation of SPADEs and their intended uses is needed prior to nationwide implementation and adoption.**

Following the development of a framework for prioritizing the SPADE elements, we ask that the agency lay out a multi-year plan for implementation. The current proposal of implementation by October 1, 2020, is not workable from an operational and IT infrastructure perspective. However, with additional time and shared understanding of future goals, providers can prioritize staff training and sequence IT resources to ensure smooth implementation of each of the prioritized data elements.

This multi-step approach would allow IRFs and CMS the opportunity to develop and manage their coding, assessment, and documentation procedures in a comprehensive and thoughtful manner, and it would provide more lead time to collaborate with key partners. Understanding how the data are intended to be used is critical to this process.

CHA appreciates the opportunity to comment on the FFY 2020 IRF PPS proposed rule. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688; or my colleague Pat Blaisdell, vice president continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/

Alyssa Keefe

Vice President Federal Regulatory Affairs