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June 18, 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-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 Proposed Rule, Federal Register (Vol. 84, No.80), April 25, 2019

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, including approximately 100 hospital-based skilled-nursing facilities (SNFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) SNF prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2020.

CHA supports and appreciates CMS' proposals to:

- Change the definition of group therapy to align with other post-acute care settings.
- Adopt a process to allow for timely updating of non-substantive changes to the ICD-10 data set for purposes of patient assignment under the Patient Driven Payment Model (PDPM).
- Update regulatory text to reflect changes to the resident assessment schedule associated with the implementation of PDPM.
- Change the specifications for the SNF Quality Reporting Program (QRP) measure "Discharge to Community – PAC."

CMS currently uses the FFY 2020 unadjusted hospital area wage index to adjust skilled nursing facility payments. CHA strongly opposes the use of the current FFY 2020 wage index data that was released as a public use file on April 30. 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.

Specific to CMS' proposals for multiple additions to data collection and patient assessment, including the implementation of standardized patient assessment data elements (SPADEs), CHA urges CMS to:

1. **Reduce the speed and scope of SPADE implementation.** Absent a gradual, considered timeline for implementation, SNFs are forced to continuously add new elements and processes to ones that already exist, without time to assess and test a redesigned workflow process that could

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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 SPADEs so post-acute care providers, including SNFs, 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 minimum data set (MDS) for prioritizing implementation of the critical SPADEs.** 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** that allows SNFs 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 is 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 SNFs — 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 SNF providers. Rethinking this implementation — and staging it appropriately — will benefit both providers and CMS in the long term. Our detailed comments are noted below.

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 SNF PPS CASE-MIX SYSTEM FOR FFY 2020

As finalized in the FFY 2019 SNF PPS final rule, effective October 2019, the existing SNF case-mix classification system, RUG-IV, will be replaced by the PDPM. In the current proposed rule, CMS updates payment rates with more recent payment year data in a budget-neutral manner.

CHA supports the overall goals of the revised case-mix methodology, including the transition away from rates largely driven by therapy utilization to those based on patient characteristics. However, we are acutely aware that the implementation of PDPM represents a major change for SNFs, which will require significant staff training and adjustment.

Additionally, the effect of PDPM implementation on access to SNF care is unclear. The current RUG-IV payment system provides a strong incentive to SNFs to admit and treat individuals whose primary need is therapy services over those who present with complex medical conditions, and access to medically necessary SNF care for non-rehab patients has been limited. CHA is in strong support of the "re-balancing" that PDPM represents and is optimistic that it will facilitate transition from hospital to SNF for medically complex patients. However, some CHA members have expressed concerns that community SNFs may react to the uncertainty of PDPM by limiting patient admissions still further.

CHA encourages CMS to provide comprehensive, accessible, and timely provider guidance and training to support a shared understanding of scoring criteria and assessment procedures. Additionally, CHA strongly urges CMS to closely monitor patient assessment data on an ongoing basis, and reassess and modify case mix groupings as needed. Finally, CHA strongly urges CMS to monitor SNF admission practices in order to identify and address any negative impact on patient access to medically necessary care.

AREA WAGE INDEX

CMS currently uses the FFY 2020 unadjusted hospital area wage index to adjust skilled nursing facility payments. 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 inpatient prospective payment system (IPPS) proposed rule, CMS verified the Worksheet S-3 wage data by instructing its Medicare administrative contractors to revise or verify data elements that result in "specific edits failures" (84 Fed. Reg. at 19375). CMS excluded 81 providers with "aberrant" data, but 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 this 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.

We urge CMS to carefully review CHA's FFY 2020 IPPS comments, where we outline in detail our **concerns and objections to the proposed exclusion of the seven hospitals in the FFY 2020 public use file. As discussed below, 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, CMS' threat to exclude all seven hospitals in FFY 2021 is completely untethered from the relevant statute and is unsupportable. Further, the proposed exclusions for FFY 2020 will cause significant harm to not only IPPS hospitals, but also SNFs, inpatient rehabilitation hospitals (IRFs), inpatient psychiatric facilities and many others. These consequences impacting more than the IPPS hospitals appear to be unintended by CMS, as it failed to even consider them in its regulatory fiscal impact analysis in the proposed rule as it is legally required to do. Thus, the exclusions are legally impermissible.

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%

CHA estimates the cost to hospital based SNFs in California is nearly $600,000 for FFY 2020.

GROUP THERAPY DEFINITION
CHA supports the proposed revisions to the definition of group therapy. CHA appreciates CMS' recognition that this change would provide greater flexibility for therapists in SNFs, allowing them to apply their clinical judgment when determining the role and value of group treatment as well as the appropriate group size for their patients. We also recognize the value of aligning the definition across settings, particularly between SNFs and IRFs, where therapy services are a central component of the services provided.

UPDATING ICD-10 CODE MAPPINGS
CHA supports CMS' proposal to apply non-substantive changes to the ICD-10 using a subregulatory process and make substantive changes through notice and comment rulemaking. PDPM utilizes ICD-10 codes to assign patients to clinical categories and determine certain co-morbidities. The ICD-10 Coordination and Maintenance Committee regularly publishes updates, and federal regulations require providers to follow the most up-to-date coding. The subregulatory process currently proposed by CMS will support the timely implementation of changes in coding and ensure additional consideration is given to substantive changes that amount to a change in policy.

CHANGES TO ASSESSMENT SCHEDULE
CHA supports the proposed revisions to regulatory text addressing changes to the required patient assessment schedule, in particular clarification that SNFs are responsible to recognize when it is

necessary to complete an Interim Payment Assessment (IPA) to account for changes in patient care needs. At the same time, we recommend that CMS collect and share information about this process, to ensure that assessments — and related reimbursement — are as accurate as possible and that SNFs are initiating IPAs appropriately.

SKILLED-NURSING FACILITY QUALITY REPORTING PROGRAM
CHA supports the proposed changes to the SNF 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 SNF 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, SNFs would be required to submit data on these measures beginning in October 2020.

CMS notes that the two measures have been conditionally supported by the National Quality Forum (NQF)'s 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 to 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 SNF 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 SNF 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 to implement 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, IRFs, 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 SNF PPS proposed rule, CMS proposed requiring SNFs 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 for the testing of proposed SPADEs in real-world clinical settings, and for meaningful input from working clinicians and managers in post-acute care settings. However, CHA believes that the value of the data is 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 steps to recruit a number of providers and settings in several geographic areas, it is unclear whether any hospital-based SNFs were included in the sampling. As compared to free-standing SNFs, smaller hospital-based units often see patients of greater medical complexity and/or with a wider range of socioeconomic needs, reflective of the local community. The low sample size of SNFs (60, representing approximately 0.3% of all SNFs) and Medicare stays (1167, approximately 0.05% of total annual Medicare stays) raises serious concerns as to whether it is representative of the larger SNF community or the types of patients cared for in this setting.

CHA members have expressed grave concerns about the beta test's reported exclusion of patients with communication and cognitive impairments, who comprise a significant portion of SNF 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 SNF 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 SNF patients 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 a 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 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, that uses a proxy for SDOH to help inform next steps in data collection at the patient level. While well-intended, assuming the proposed items are applicable and valuable — absent any analytic support — 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 SNFs. 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 note that the time to assess patients, as reported by contractors, did not reflect their experience. Due to the previously discussed limitations in beta test patient sampling, the time and costs associated with administration for the full SNF 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 post-acute care 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 SNFs 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 limits SNFs' 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, SNFs are forced to continuously add new elements and processes to those 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 SNFs 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 the ability 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 SNFs, 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 MDS 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 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 items to the MDS has been lost. Before proceeding with full implementation, the agency should explain why certain data elements can **only** be obtained through the MDS 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 SNFs 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 MDS without requiring additional assessment and documentation by the SNF. 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 a SNF have a significant cognitive and/or communicative impairment. In fact, in some SNFs these patients 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 additional review of the collected data and the operational impact on SNFs.** 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 SNFs 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 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 SNF facilities 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.

CHA appreciates the opportunity to comment on the FFY 2020 SNF 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