



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

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Stella Mandl, RN, BSN, BSW, PHN
Director
Centers for Medicare & Medicaid Services
Division of Chronic and Post-Acute Care

Mary Pratt, MS, RN
Deputy Director
Centers for Medicare & Medicaid Services
Division of Chronic and Post-Acute Care

Submitted via email: spadeforum@rand.org

RE: Early Findings from the National Beta Test of Standardized Patient Assessment Data Elements

Dear Ms. Mandl and Ms. Pratt:

On behalf of our more than 400 member hospitals and health systems, including approximately 300 hospital-based post-acute care providers, the California Hospital Association (CHA) appreciates the opportunity to provide feedback on RAND's national beta test of candidate standardized patient assessment data elements (SPADEs).

CHA supports the objectives of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, including the development of SPADEs as well as data collection across all levels of post-acute care to ensure high-quality patient care. We agree that such data collection and standardization, when performed correctly and consistently, will better align Medicare payments for services with beneficiaries' clinical characteristics.

CHA appreciates the Center for Medicare & Medicaid Services' (CMS) efforts to release early findings of the national beta test for stakeholders' review and discussion. This input has been key throughout measure development and testing, and has brought shared understanding to this process. We applaud CMS for providing multiple engagement opportunities over the past several years and we urge CMS to continue this dialogue as we move forward.

CMS should build on the steps it has taken to date and allow access to the data set that was developed as part of the national beta test. 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.

While not a nationally representative data set, it contains tremendous information. Allowing all parties access will lead to a richer and more informed policy discussion going forward. Releasing the data set as early as possible would benefit CMS in that 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.

A technical appendix in support of this data set would also be helpful to stakeholders. We also appreciate CMS' efforts to return data to the organizations that have participated so that they can benefit from those learnings.

This administration has been committed to transparency of data, and continues to release information across many areas on an ongoing basis. We believe our request aligns with the agency's overall priorities and goals. Further, absent a fully transparent process, it is nearly impossible to provide meaningful input on such significant changes.

Change is difficult, but it is made even more challenging when providers are not given adequate information to make informed strategic and operational decisions. Unfortunately, in many areas of payment and coverage policy, CMS woefully underestimates the time providers need make the cultural and organizational changes that are being requested — especially while simultaneously ensuring beneficiary access is not limited. **Therefore, CHA urges CMS to look for additional ways — outside a very limited rulemaking process — to engage providers as we continue on this transformation journey. We acknowledge that this is a time-consuming and difficult task. However, we believe it is critical and fundamental as CMS proceeds. Resources and personnel should be dedicated to this process. CHA stands ready to work with CMS to help inform next steps.**

As previously mentioned, CHA appreciates CMS' efforts to engage stakeholders. However, we hope the agency will provide additional opportunities prior to implementation of the SPADEs. When given the opportunity, CHA and our member organizations have been actively engaged in developing the SPADEs. This has included participation in technical expert panels, open door forums, previous public comment periods and the national beta test. However, while CHA member organizations participated in the national beta testing in the California markets, we are unaware of any field staff focus groups held with those organizations, as discussed in the November meeting. We see this as a missed opportunity to solicit provider feedback on their experiences with the candidate SPADEs and would welcome an opportunity to assist in a future convening.

In addition, as stated in our comments on the federal fiscal year (FFY) 2019 inpatient rehabilitation facility prospective payment system final rule, we continue to urge CMS to create a multi-disciplinary technical advisory group representing the full continuum of post-acute care providers to advise the agency on the technical, strategic and operational implications that should be considered as these changes go forward. To date, stakeholder input for measure development and testing has been approached within each setting type, limiting the opportunity for comparison across settings. Not only is such an approach counterintuitive to the overall goal of increasing alignment across settings, but — in our view — it also limits the scope and value of the input received.

Finally, CHA supports many of the design elements of the national beta test, including steps to better test reliability across settings and data elements. However, our members — particularly those that participated in the beta test — are increasingly concerned that the data do not adequately recognize the frequency of cognitive and communication impairments or their impact on the care process. Patients

with significant communication or cognitive impairments were omitted from the study, due to their inability to participate in the interview process. This omission causes providers great concern.

The presence of a cognitive or communicative impairment will significantly impact the care process and associated resource use. For example, in a case where two patients have similar levels of functional mobility but only one has a cognitive impairment, the patient with deficits in comprehension, memory or safety awareness will require significantly more intervention.

The limited assessment of cognitive and communication impairments, as well as the elimination of many patients from the data collection process, undermines both the comparability of the patients assessed to the general population cared for in post-acute settings and the ability to draw conclusions about the use of these measures in clinical post-acute care. We urge CMS to consider these implications as it reviews the national beta test findings.

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. Their omission from the testing process limits our ability to assess the value of the measures in a diverse patient population, and brings into question the measures' validity. CHA looks forward to additional discussion on these important matters.

Thank you for the opportunity to provide comments on the early findings of the beta test. If you have any questions, please contact me at akeefe@calhospital.org or (202) 488-4688.

Sincerely,

/s/

Alyssa Keefe

Vice President, Federal Regulatory Affairs

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