**CENTER FOR POST-ACUTE CARE**  
Wednesday, January 28, 2015  
1:00PM – 5:00PM  
Hilton Waterfront Beach Resort  
Dolphin Room  
21100 Pacific Coast Highway  
Huntington Beach, CA 92648  

Call-in: (800) 882-3610; Passcode: 0523939#

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<thead>
<tr>
<th>ITEM</th>
<th>SUBJECT</th>
<th>REPORTING</th>
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<tbody>
<tr>
<td>I.</td>
<td>CALL TO ORDER/INTRODUCTIONS</td>
<td>Hirose</td>
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<td></td>
<td>A. Advisory Board Membership Update</td>
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<td>– 2015 Roster</td>
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<td>II. MINUTES OF PREVIOUS MEETING</td>
<td>Hirose</td>
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<td>A. Post-Acute Care Advisory Board Meeting</td>
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<td></td>
<td>– December 13, 2015 call meeting minutes*</td>
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<td>*Recommendation: Approve meeting minutes</td>
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<td></td>
<td>III. CHAIR REPORT</td>
<td>Hirose</td>
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<td>A. Meeting Welcome and Review</td>
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<td>B. CHA Board of Trustees</td>
<td>Hirose/Brown</td>
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<td>Blaisdell</td>
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<td>– Packets to be distributed</td>
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<td>B. Annual Meeting</td>
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<td>C. Post-Acute Care PPT “Toolkit”</td>
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<td>C. Home Health &amp; Hospice Forum</td>
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<td>– LTCH Provider Report</td>
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<tr>
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<td>All</td>
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<tr>
<th>X. NEXT MEETING</th>
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<tr>
<td>In-Person Meeting:</td>
<td>Hirose</td>
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<tr>
<td>Tuesday, April 14, 2015</td>
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<td>10:00 am- 2:30 pm</td>
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<tr>
<td>CHA- Board Room</td>
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<tr>
<td>1215 K Street, Suite 800</td>
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<td>Sacramento, CA 95814</td>
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<th>XI ADJOURNMENT</th>
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<td></td>
<td>Hirose</td>
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# Center for Post-Acute Care
## 2015 Advisory Board Roster

<table>
<thead>
<tr>
<th>Chair</th>
<th>Chair-Elect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mivic Hirose, RN, MSN, CNS, Executive Administrator</strong>&lt;br&gt;Laguna Honda Hospital and Rehabilitation Center&lt;br&gt;375 Laguna Honda Blvd.&lt;br&gt;San Francisco, CA 94116&lt;br&gt;Phone: 415-759-2363&lt;br&gt;Fax: 415-759-2374&lt;br&gt;<a href="mailto:mivic.hirose@sfdph.org">mivic.hirose@sfdph.org</a></td>
<td><strong>Pamela Chevreaux, MA, VP Ambulatory Services</strong>&lt;br&gt;Long Beach Memorial Medical Center&lt;br&gt;2801 Atlantic Avenue&lt;br&gt;Long Beach, CA 90806&lt;br&gt;Phone: 562-933-9010, 562-233-2556 (cell)&lt;br&gt;Fax: 562-933-1904&lt;br&gt;<a href="mailto:pchevreaux@memorialcare.org">pchevreaux@memorialcare.org</a></td>
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**Term: 2011-2016**

<table>
<thead>
<tr>
<th>Past-Chair</th>
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<tbody>
<tr>
<td><strong>David Brown, System Director of Rehabilitation Services</strong>&lt;br&gt;Sharp HealthCare&lt;br&gt;2999 Health Center Drive&lt;br&gt;San Diego, CA 92123&lt;br&gt;Phone: 858-939-3085&lt;br&gt;Fax: 858-939-3117&lt;br&gt;<a href="mailto:david.brown@sharp.com">david.brown@sharp.com</a></td>
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**Term: 2011-2015**

<table>
<thead>
<tr>
<th>Members</th>
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<tbody>
<tr>
<td><strong>Maria Cecilia Alpasan, MA, OTR/L, Quality and Education Coordinator, Department of Rehabilitation</strong>&lt;br&gt;Cedars-Sinai Medical Center&lt;br&gt;8700 Beverly Blvd.&lt;br&gt;Los Angeles, CA 90048&lt;br&gt;Phone: 310-423-5243&lt;br&gt;<a href="mailto:alpasanm@cshs.org">alpasanm@cshs.org</a></td>
</tr>
</tbody>
</table>

**Term: 2015-2017**

| **Sheila Brown, RN, FACHE, Chief Administrative Officer**<br>Palomar Health<br>555 E. Valley Parkway<br>Escondido, CA 92025<br>Phone: 760-739-3367<br>Fax: 760-739-3107<br>[sheila.brown@palomarhealth.org](mailto:sheila.brown@palomarhealth.org) |

**Term: 2014-2016**
| Judy Cook, RN, Administrative Director  
Seton Medical Center  
1900 Sullivan Ave  
Daily City, CA 94015  
Phone: 650-563-7123  
Fax: 650-563-7129  
judycoc@dochs.org  
  
Term: 2009-2015 | Todd Cook, Chief Care Management Officer  
Providence Health & Services  
501 South Buena Vista Street  
Burbank, CA 91505  
Phone: 818-847-3307  
Fax: 888-581-9031  
todd.cook@providence.org  
  
Term: 2011-2017 |
|---|---|
| Margaret Crane, Chief Executive Officer  
Barlow Respiratory Hospital  
2000 Stadium Way  
Los Angeles, CA 90026  
Phone: 213-202-6885  
Fax: 213-202-6801  
mcranbrlow200.org  
  
Term: 2011-2016 | Adam Darvish, SVP Hospital Division  
Kindred Healthcare  
200 Hospital Circle  
Westminster, CA 92683  
Phone: 714-893-4541 x5147  
Fax: 714-899-5057  
adam.darvish@kindredhealthcare.com  
  
Term: 2011-2017 |
| Paul Giles, Director of Home Health Finance  
Dignity Health  
20525 Via Lerida  
Yorba Linda, CA 92887  
Phone: 415-987-6623  
Fax: 415-591-2432  
Paul.Giles@dignityhealth.org  
  
Term: 2014-2016 | Linda Glomp, RN, BSN, MBA, Executive Director  
St. Joseph Health, Home Health, Hospice, Infusion Pharmacy, Private Duty  
1100 West Stewart Drive  
Orange, CA 92863  
Phone: 714-712-7236  
Fax: 714-712-7157  
linda.glomp@stjoe.org  
  
Term: 2011-2017 |
| Lisa Harrold, LCSW, Director, Rehabilitation and Skilled Nursing Services  
Kaweah Delta Health Care District  
840 S Akers Road  
Visalia, CA 93277  
Phone: 559-624-3854  
Fax: 559-741-4725  
lharrold@dhdcd.org  
  
Term: 2015-2017 | Walter Hekimian, MBA, Administrator  
Edgemoor DPSNF  
655 Park Center Drive  
Santee, CA 92071  
Phone: 619-596-5597  
Fax: 619-596-5501  
walter.hekimian@sdcouny.ca.gov  
  
Term: 2014-2016 |
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
<th>Term</th>
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<tbody>
<tr>
<td>James Jackson, MPH, Hospital Administrator</td>
<td>Hospital Administrator</td>
<td>Alameda County Medical Center, Fairmont Campus</td>
<td>15400 Foothill Blvd.</td>
<td>510-895-7206</td>
<td>510-895-4237</td>
<td><a href="mailto:jajackson@alamedahealthsystem.org">jajackson@alamedahealthsystem.org</a></td>
<td>Term: 2014-2016</td>
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<tr>
<td></td>
<td></td>
<td>San Leandro, CA 94578</td>
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<tr>
<td>Jan Kroetz, RN, NM, NE-BC, Chief Patient</td>
<td>Patient Care Director</td>
<td>Loma Linda University Medical Center- East Campus</td>
<td>25333 Barton Road</td>
<td>909-558-6609</td>
<td>909-558-6669</td>
<td><a href="mailto:jkroetz@llu.edu">jkroetz@llu.edu</a></td>
<td>Term: 2013-2015</td>
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<td>Loma Linda, CA 92354</td>
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<tr>
<td>Josh Luke, Ph.D., FACHE, Interim Chief</td>
<td>Interim Chief Executive Officer</td>
<td>Memorial Hospital of Gardena</td>
<td>1145 W. Redondo Beach Blvd.</td>
<td>310-538-6500</td>
<td></td>
<td><a href="mailto:jluke@avantihospitals.com">jluke@avantihospitals.com</a></td>
<td>Term: 2015-2017</td>
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<td>Gardena, CA 90247</td>
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<tr>
<td>Shelly Necke, RN, BSN, Administrative</td>
<td>Administrative Director, Transitional Care</td>
<td>Acute Rehabilitation Center, PIH Health</td>
<td>12401 Washington Blvd.</td>
<td>562-698-0811 x12542</td>
<td></td>
<td><a href="mailto:shelly.necke@pihhealth.org">shelly.necke@pihhealth.org</a></td>
<td>Term: 2015-2017</td>
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<tr>
<td>Jan Potts, RN, MBA, Chief Clinical</td>
<td>Chief Clinical Executive</td>
<td>Sutter Care at Home</td>
<td>4830 Business Center Drive, Suite 140</td>
<td>707-864-4556</td>
<td>707-863-9043</td>
<td><a href="mailto:pottsj@sutterhealth.org">pottsj@sutterhealth.org</a></td>
<td>Term: 2011-2017</td>
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<tr>
<td></td>
<td>Executive</td>
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<tr>
<td>Pamela Reger, Director, Continuing Care</td>
<td>Director, Continuing Care Services</td>
<td>Kaiser Permanente</td>
<td>10990 San Diego Mission</td>
<td>619-641-4026, (cell)</td>
<td>619-641-2025</td>
<td><a href="mailto:pamela.g.reger@kp.org">pamela.g.reger@kp.org</a></td>
<td>Term: 2011-2017</td>
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<tr>
<td>Martha Samora, RN, CPHQ, FACHE, Chief</td>
<td>Chief Executive</td>
<td>HealthSouth Bakersfield Rehabilitation Hospital</td>
<td>5001 Commerce Drive</td>
<td>661-864-4073</td>
<td>661-633-5254</td>
<td><a href="mailto:martha.samora@healthsouth.com">martha.samora@healthsouth.com</a></td>
<td>Term: 2015-2017</td>
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<tr>
<td></td>
<td>Executive</td>
<td>Bakersfield, CA 93301</td>
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<tr>
<td>Tory Starr, MSN, PHN, CIC, Care Coordination</td>
<td>Executive</td>
<td>Sutter Health, Sacramento/Sierra Region</td>
<td>2700 Gateway Oaks Drive</td>
<td>916-887-7049</td>
<td></td>
<td><a href="mailto:starrva@sutterhealth.org">starrva@sutterhealth.org</a></td>
<td>Term: 2015-2017</td>
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<td><strong>Robert Walters, PT, MBA, Director, Inpatient Rehabilitation Services</strong></td>
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<td>John Muir Health</td>
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<td>3480 Buskirk Ave., Suite 150</td>
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<td>Phone: 925-947-5252</td>
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<td><a href="mailto:robert.walters@johnmuirhealth.com">robert.walters@johnmuirhealth.com</a></td>
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<thead>
<tr>
<th><strong>Ex-Officio</strong></th>
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<tbody>
<tr>
<td><strong>Patty Haggen, Executive Director, Neurosciences, Orthopedics &amp; Rehabilitation</strong></td>
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<tr>
<td>John Muir Health</td>
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<tr>
<td>1601 Ygnacio Valley Road</td>
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<tr>
<td>Walnut Creek, CA 94598</td>
<td></td>
</tr>
<tr>
<td>Phone: 925-941-4050</td>
<td></td>
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<tr>
<td>Fax: 925-947-3380</td>
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</tr>
<tr>
<td><a href="mailto:patty.haggen@johnmuirhealth.com">patty.haggen@johnmuirhealth.com</a></td>
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<thead>
<tr>
<th><strong>Regional Association Representatives</strong></th>
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<tbody>
<tr>
<td><strong>Jaime Garcia, Regional VP</strong></td>
<td><strong>Suzanne Ness, Regional VP</strong></td>
</tr>
<tr>
<td>Hospital Association of Southern California (HASC)</td>
<td>Hospital Council of Northern &amp; Central California</td>
</tr>
<tr>
<td>515 S Figueroa St, Suite 1300</td>
<td>1215 K Street, Suite 730</td>
</tr>
<tr>
<td>Los Angeles, CA 90071-3300</td>
<td>Sacramento, CA 95814</td>
</tr>
<tr>
<td>Phone: 213-538-0700</td>
<td>Phone: 916-552-7534</td>
</tr>
<tr>
<td>Fax: 213-629-4272</td>
<td>Fax: 916-552-2618</td>
</tr>
<tr>
<td><a href="mailto:jgarcia@hasc.org">jgarcia@hasc.org</a></td>
<td><a href="mailto:sness@hospitalcouncil.net">sness@hospitalcouncil.net</a></td>
</tr>
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<td></td>
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<tr>
<td><strong>Judith Yates, Senior VP</strong></td>
<td></td>
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<tr>
<td>Hospital Association of San Diego &amp; Imperial Counties</td>
<td></td>
</tr>
<tr>
<td>5575 Ruffin Road, Suite 225</td>
<td></td>
</tr>
<tr>
<td>San Diego, CA 92123</td>
<td></td>
</tr>
<tr>
<td>Phone: 858-614-1557</td>
<td></td>
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<td>Fax: 858-614-0201</td>
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<tr>
<td><a href="mailto:jyates@hasdic.org">jyates@hasdic.org</a></td>
<td></td>
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<tr>
<td>Staff</td>
<td>Marisa Ward, Administrative Assistant</td>
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<tr>
<td>Patricia L. Blaisdell, FACHE, VP, Post-Acute Care Services</td>
<td>California Hospital Association</td>
</tr>
<tr>
<td>California Hospital Association</td>
<td>1215 K Street, Suite 800</td>
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<tr>
<td>1215 K Street, Suite 800</td>
<td>Sacramento, CA 95814</td>
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<tr>
<td>Sacramento, CA 95814</td>
<td>Phone: 916-552-7553</td>
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<tr>
<td>Phone: 916-552-7553</td>
<td>Fax: 916-554-2293</td>
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<tr>
<td>Fax: 916-554-2253</td>
<td><a href="mailto:mward@calhospital.org">mward@calhospital.org</a></td>
</tr>
<tr>
<td><a href="mailto:pblaisdell@calhospital.org">pblaisdell@calhospital.org</a></td>
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Center for Post-Acute Care Advisory Board Meeting
Thursday, December 18, 2014
3:00 pm – 4:00 pm
Conference Call

Present:  David Brown, Sheila Brown, Todd Cook, Paul Giles, Walter Hekimian, Mivic Hirose, Deborah Kania, Suzanne Ness, Jan Potts, Pamela Reger, Pamela Roberts, Rob Walters

Staff:  Pat Blaisdell, Marisa Ward

Regional Association Staff:  Jaime Garcia

I. CALL TO ORDER/INTRODUCTIONS

Chair Brown called the meeting to order at 3:02 pm.

II. MINUTES OF PREVIOUS MEETING

The minutes of the October 14, 2014 meeting were reviewed and approved.

III. CHAIR REPORT

A. Advisory Board Leadership

Chair Brown updated the board on changes to the advisory board leadership for 2015. Mivic Hirose will assume the role of chair and Pamela Chevreaux has been appointed to chair-elect. Hirose and Chevreaux will represent the Center on the CHA Board of Trustees.

B. CHA Board Of Trustees

Chair Brown provided an update on the most recent meeting of the CHA Board of Trustees.
IV. **VICE PRESIDENT REPORT**

A. Annual Meeting

Staff Blaisdell provided an update on the 2015 Annual Meeting. The meeting will once again be held at the Hilton Waterfront Resort in Huntington Beach on January 29-30, 2015.

B. Toolkit

Members were reminded that draft outlines of presentation materials are available for comment on the CHA website.

- Blaisdell will send out a reminder e-mail with link.
- Blaisdell will also provide to the group a copy of the PowerPoint from a recent presentation at MemorialCare Health System with Pamela Chevreax regarding the IMPACT Act.

V. **CURRENT ISSUES/UPDATES**

A. MAP Quality Measures

Advisory board member Pamela Roberts, who serves on the Measure Application Partnership, reported on the most recent meeting and discussion of quality measure for post-acute care settings. Roberts also provided an updated on the NQF re-admission measures currently under consideration.

B. Provider Updates

Blaisdell provided a brief update of current issues addressed in the provider forums.

- MedPAC Site Neutral Payment Proposal
- Medicare Advantage Authorizations
- DME POS Competitive Bidding
- DP/NF Clawback
- Home Health PPS final rule
- HH Conditions of Participation
- OIG work plan

C. State Legislation

Blaisdell provided a brief update of issues that may be addressed in the upcoming legislative session, to start in January 2015.

VI. **ADJOURNMENT**

- 2015 Meeting Schedule
January 28, 2015

TO: Center for Post-Acute Care Advisory Board
FROM: Mivic Hirose, Chair
Pamela Chevreaux, Chair-elect

SUBJECT: CHA Center for Post-Acute Care Chair Report

SUMMARY

Mivic Hirose chairs the Advisory Board of the Center for Post-Acute Care. Hirose and Chair-elect Pamela Chevreaux represent the Center on the CHA Board of Trustees.

ACTION REQUESTED

➢ To provide an update on CHA Board of Trustees activity
➢ To provide an update on Center advisory board membership

DISCUSSION

The Center for Post-Acute Care represents the interests of CHA member post-acute care providers, including inpatient rehabilitation hospitals and units, long-term acute care hospitals, distinct-part skilled-nursing facilities, and home health agencies. As a part of CHA, the Center for Post-Acute Care serves as the primary public policy arm of the hospital association for post-acute care issues.

The Advisory Board consists of no more than 24 members, representative of the types, location, and size of institutional members. The Chair and Chair-elect of the Advisory Board serve on the CHA Board of Trustees.

Changes to the 2015 advisory board leadership were made following the untimely death of Ed Palacios, who had been slated to assume the role of Chair. Chair-elect Hirose moved to the position of Chair, and Pamela Chevreaux was appointed as Chair-elect.

Stan Berry, who had been scheduled to start a three year term as a member of the advisory board, has left his position with Adventist health and consequently will not join the board.

Attachments Advisory Board Roster
January 28, 2015

TO: Center for Post-Acute Care Advisory Board  
FROM: Patricia Blaisdell, Vice President, Post-Acute Care Services  
SUBJECT: CHA Center for Post-Acute Care Vice President Report

SUMMARY

The CHA Center for Post-Acute Care offers representation for CHA members who provide inpatient rehabilitation, long-term acute care, skilled nursing, and home health and hospice services.

ACTION REQUESTED

- To provide an overview of 2015 board orientation materials.
- To provide an update on the 2015 annual meeting.
- To provide an update on the development and comment process for the Post-Acute Care tool kit and determine next steps as appropriate.

DISCUSSION

The Vice President for the Post-Acute Care provides support to the Center for Post-Acute Care and members of the advisory board.

Advisory board members had previously suggested that Center staff develop presentation materials that may be accessed and used by members to support communications about post-acute care services, their role in the continuum of care and health care reform, and the work of the Center. A draft outline has been developed and is posted for discussion on the CHA website.

Attachments Orientation Packets
January 28, 2015

TO: Center for Post-Acute Care Advisory Board

FROM: Robert Walters, Chair, Inpatient Rehabilitation and Therapy Services Forum

SUBJECT: Report of Forum Activities

SUMMARY

The Inpatient Rehabilitation and Therapy Services Forum provides input into the work of the Center and advises CHA leadership on issues of concern to providers of inpatient rehabilitation facilities and therapy services.

Robert Walters chairs the Inpatient Rehabilitation and Therapy Services Forum and represents the forum on the advisory board of the Center for Post-Acute Care.

ACTION REQUESTED

➢ To provide attendees an update regarding issues impacting inpatient rehabilitation facilities (IRFs) and therapy services.

DISCUSSION

A. Quality Indicators

Members of the forum provided input on proposed quality indicators under consideration by the Measures Application Partnership (MAP). The MAP, convened by the National Quality Forum, will review the list and provide recommendations to CMS for their consideration for adoption in future rulemaking. Pamela Roberts, Ph.D., from CHA member hospital Cedars-Sinai Medical Center, is a member of the MAP. Based on the input received, CHA submitted comments regarding the proposed measures.

B. Site-Neutral Payment

The Medicare Payment Advisory Commission (MedPAC) has advanced a proposal for the development and implementation of site-neutral payment for certain patients cared for in skilled
nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). Under these proposals, payments to IRFs and SNFs would be equalized for individuals who have certain diagnoses, including patients who have undergone hip or knee procedures, or who have certain medical diagnoses. Forum members discussed implications and issues related to site-neutral payments, and provided input to CHA’s future advocacy efforts on this issue.

C. Managed Medicare Authorization

Several CHA member IRFs have reported difficulty obtaining authorization for medically necessary admissions to inpatient rehabilitation facilities. CHA staff members Blaisdell and Keefe initiated communication on this issue with personnel at Region IX of the Centers for Medicare & Medicaid Services (CMS), and will continue to monitor member experience.

D. Outpatient Therapy Services

The Centers for Medicare & Medicaid Services (CMS) announced the values for the therapy caps for calendar year 2015. The therapy cap amount is $1,940 for physical therapy and speech-language pathology combined, with a separate $1,940 cap for occupational therapy. The therapy caps are annual financial limitations on reimbursement for outpatient therapy services.

E. IRF-PAI

CMS has added information to Section 2 of the inpatient rehabilitation facility patient assessment instrument (IRF-PAI) training manual, as provided for in the fiscal year (FY) 2015 IRF prospective payment system final rule. The new IRF-PAI items – effective Oct. 1, 2015 – include Arthritis Attestation (item 24A) and Therapy Information Section (items O0401 and O0402). CMS has also made changes to the manual’s Helpful Resources document.

F. DME

CHA continued its work to address member concerns regarding the ability of member hospitals to obtain medically necessary durable medical equipment (DME) since the initiation of the CMS Competitive Bidding Program for the durable medical equipment prosthetics, orthotics and supplies (DMEPOS). CHA facilitated communication between hospital personnel and representatives from Palmetto GBA, the Medicare Administrative Contractor (MAC) for the DMEPOS competitive bidding program. CMS has announced the bidding timeline for round 2 of the program, including a deadline for suppliers of March 25.
January 28, 2015

TO: Center for Post-Acute Care Advisory Board
FROM: Walter Hekimian, Chair, Skilled Nursing and Subacute Care Services Forum
SUBJECT: Report of Forum Activities

SUMMARY

The Skilled Nursing and Subacute Care Services Forum provides for member input into the work of the Center and advises CHA leadership on issues of concern to providers of hospital-based skilled nursing facilities and subacute care units.

Walter Hekimian chairs the Skilled Nursing and Subacute Care Services Forum and represents the forum on the advisory board of the Center for Post-Acute Care.

ACTION REQUESTED

➢ To provide attendees an update regarding issues impacting hospital-based skilled nursing units and subacute care units.

DISCUSSION

A. DP/NF Medi-Cal Rate Reductions

CHA continues to advocate for the elimination of the “clawback,” or retroactive recoupment of reimbursement for services provided by distinct part skilled nursing facilities for the time period from June 1, 2011 to September 30, 2013 (August 31, 2013 for rural facilities). CHA leadership is engaged in direct discussions with HHS/DHCS, and will address in legislation or other action in 2015 if the matter is not resolved before then.

At present, DHCS indicates that it plans to proceed with implementation of recoupment in the future. Recoupment will be initiated at a later date via a 5% withhold on check writes. Facilities
will receive notification prior to the beginning of recoupment, and will be able to request alternative payment arrangements.

**B. Site-Neutral Payment**

The Medicare Payment Advisory Commission (MedPAC) has advanced a proposal for the development and implementation of site-neutral payment for certain patients cared for in skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). Under these proposals, payments to IRFs and SNFs would be equalized for individuals who have certain diagnoses, including patients who have undergone hip or knee procedures, or who have certain medical diagnoses. Forum members discussed implications and issues related to site-neutral payments, and provided input to CHA’s future advocacy efforts on this issue.

**C. SNF PPS Payment Reform Research**

The Centers for Medicare & Medicaid Services (CMS) is expanding the scope of its skilled-nursing facility (SNF) payment reform project to examine potential improvements and refinements to the overall SNF prospective payment system (PPS). In the first two phases of the project, the contractor focused on SNF PPS therapy payment by reviewing current policy and research and identifying potential therapy models suitable for further analysis. CMS is considering stakeholder comments and concerns as it continues to investigate alternative therapy payment approaches.

**D. Quality Measures**

Members of the forum provided input on proposed quality indicators under consideration by the Measures Application Partnership (MAP). The MAP, convened by the National Quality Forum, will review the list and provide recommendations to CMS for their consideration for adoption in future rulemaking. Pamela Roberts, Ph.D., from CHA member hospital Cedars-Sinai Medical Center, is a member of the MAP. Based on the input received, CHA submitted comments regarding the proposed measures.
January 28, 2015

TO: Center for Post-Acute Care Advisory Board

FROM: Linda Glomp, Home Health and Hospice Forum

SUBJECT: Report of Forum Activities

SUMMARY

The Home Health and Hospice Forum provides for member input into the work of the Center and to advise CHA leadership on issues of concern to providers of home health and hospice services and agencies operated by or affiliated with CHA member hospitals.

Linda Glomp chairs the Home Health and Hospice forum and represents the forum on the advisory board of the Center for Post-Acute Care.

ACTION REQUESTED

➢ To provide attendees an update regarding issues impacting home health agencies and hospices.

DISCUSSION

A. HH PPS

The final rule for the home health prospective payment system was published in the November 6, Federal Register. Under the final rule, including implementation of payment updates and the second year of a four-year rebasing, CMS estimates that payments to home health agencies will decrease 0.3 percent compared to 2014.

CMS also finalized a proposal, supported by CHA, to simplify requirements for the “face-to-face” physician certification process by eliminating the inclusion of a narrative in the physician’s certification in most cases, and made other significant changes to the certification process. CHA will monitor the impact of the changes on member experiences and beneficiary access to care.
In addition, CMS will revise the schedule for therapy reassessments by requiring the reassessments to occur every 30 days. CHA completed a summary and analysis of the final rule. The provisions of the final rule will take effect January 1, 2015.

B. **Home Health CoPs**

The Center for Medicare and Medicaid Services issued a proposed rule updating the Medicare Conditions of Participation (CoPs) for home health agencies (HHAs). The proposed rule represents the first update to home health CoPs since 1989, and includes proposals for requirements involving patient rights; comprehensive assessment of patients; care planning, coordination of services and quality of care; infection prevention and control; skilled professional services; home health aide services; and organization environment. CHA submitted comments on behalf of members.

C. **Home Health Rebasing**

The Medicare Payment Advisory Commission (MedPAC) recently released to Congress a report assessing the impact of the rebasing of Medicare rates for home health care, as implemented by the Affordable Care Act (ACA), on beneficiary access and quality of care. In the report, MedPAC concluded that previous payment reductions did not have a negative effect on quality or beneficiary access to care and that this prior experience suggests that the ACA rebasing will not change average episode payments significantly, or have a negative impact on beneficiary access or quality. MedPAC will continue to review as empirical data of the ACA payment rebasing becomes available.

Attachments
- HH PPS Final Rule Summary
- Conditions of Participation Letter
The Centers for Medicare & Medicaid Services (CMS) has published in the November 6 Federal Register the final rule for calendar year (CY) 2015 regarding the Medicare home health prospective payment system (HH PPS). The final rule can be found at http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf.

The policy and payment provisions in the final rule will be effective for discharges in CY 2015, beginning January 1, 2015.

In addition to payment updates, CMS finalizes with minimal modifications proposals to simplify face-to-face encounter requirements and therapy reassessment timeframes, make revisions to the home health quality reporting requirements, and limit the reviewability of the civil monetary penalty provisions.

The final rule also discusses Medicare coverage of insulin injections under the HH PPS, the delay in the implementation of ICD-10-CM, and comments received on the HH value-based purchasing (HH VBP) model that CMS is considering implementing on a test basis.

**Prospective Payment Rates and Impact Analysis**

According to CMS, the projected nationwide impact of the payment changes will be a net decrease of 0.3 percent ($60 million) in home health payments in CY 2015.

**CY 2015 Home Health Market Basket Update**

CMS finalizes the HH PPS market basket update for CY 2015 of 2.6 percent, offset by a 0.4 percent productivity cut mandated by the Affordable Care Act (ACA). Home health agencies (HHAs) that meet the quality data reporting requirements are eligible for the full HH market basket percentage increase; HHAs that do not meet these requirements are subject to a two percentage point reduction to the HH market basket increase.

**Rebasing Home Health Payment Rates**

Section 3131(a) of the ACA mandates that, starting in CY 2014, the Secretary apply an adjustment to the national, standardized 60-day episode payment rate. The purpose of the update is to reflect changes in the number of visits per episode, average cost of providing care per episode and other factors. This adjustment must be phased in over a four-year period in equal increments.

The net of the 2.2 percent update and the rebasing adjustment yields an overall 0.3 percent reduction. The table below shows the projected impact for HHAs by characteristics, including ownership type and rural vs. urban.
Estimated Percentage Change of Final Policies for 2015 for HHAs with Selected Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HHAs</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Freestanding</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Facility-based</td>
<td>+1.5%</td>
</tr>
<tr>
<td>Voluntary nonprofit</td>
<td>+1.3%</td>
</tr>
<tr>
<td>Proprietary</td>
<td>-0.9%</td>
</tr>
<tr>
<td>Government</td>
<td>+1.0%</td>
</tr>
<tr>
<td>Rural</td>
<td>+0.5%</td>
</tr>
<tr>
<td>Urban</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>

**National, Standardized 60-day Episode Payment Rate**
CMS finalizes a 60-day episode rate of $2,961.38 for HHAs that submit quality data. HHAs that do not submit quality data will receive a 60-day episode rate of $2,903.47. The rural add-on of 3 percent will be provided for services in rural areas.

**Low Utilization Payment Adjustment (LUPA) Per-Visit Payment Amounts**
The table below shows the finalized per-visit rates for HH episodes with four or fewer visits.

### Final CY 2015 National LUPA Per-Visit Payment Amounts

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>CY 2014 Per-Visit Rates Including Outliers</th>
<th>Final CY 2015 Per-Visit Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>$57.89</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>$204.91</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>$140.70</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$132.40</td>
<td>$139.95</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$121.10</td>
<td>$127.83</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$143.88</td>
<td>$151.88</td>
</tr>
</tbody>
</table>

As with the payments for a 60-day episode of care, HHAs that do not submit required quality data will have the per visit rates reduced by 2 percent, and the rural add-on of 3 percent will be provided for services in rural areas.

**Nonroutine Medical Supply (NRS) Conversion Factor**
CMS finalizes rates for the six NRS severity levels based on a conversion factor of $53.23 (as compared to $53.28 in the proposed rule). Rates are listed in Table 26 (page 66089) of the final rule.
Home Health Case Mix Adjustments
CMS finalizes its proposal to recalibrate case mix weights using more current data (preliminary CY 2013 claims data for 60-day episodes only). Final weights for CY 2015 are found in Table 15 (pages 66062-66066) of the final rule.

Home Health Wage Index
As discussed in last year’s proposed rule, CMS now proposes to incorporate the new core-based statistical area (CBSA) definitions, which have been updated by the Office of Management and Budget (OMB) using 2013 census population data, using a one-year transition. CMS proposes the use of a 50/50 blend of 1) the wage index values using OMB’s previous labor market delineations and 2) the wage index values using OMB’s updated labor market delineations. Tables 13 and 14 in the proposed rule list 37 counties that would change to rural status and 105 counties that would change to urban status as a result of the updated labor markets. There are no changes affecting California counties. The CY 2015 wage index update would be applied in a budget-neutral manner, with a budget neutrality factor of 1.0012 applied to the 60-day episode rates.

Rural Add-On
As required by section 3131(c) of the ACA, a 3 percent rural add-on applies to the national, standardized 60-day episode payment rate, the national per-visit rates, the LUPA add-on payment, and the NRS conversion factor when HHS services are provided in rural (non-CBSA) areas. For example, the rural national per-episode payment rate would be $3,050.22, compared to $2,990.47 when services are furnished in non-rural areas (for HHAs meeting quality reporting requirements).

Outlier Policy
Section 1895(b)(5)(A) of the Social Security Act requires that estimated total outlier payments under HH PPS not exceed 2.5 percent of total HH payments. Current policy sets the high-cost outlier pool at this level, with a 10 percent outlier cap per agency. There are no changes to this policy.

Face-to-Face Encounter Requirement
The ACA requires that, prior to certifying a patient’s eligibility for home health benefits, a physician must document that the physician, or an allowed non-physician practitioner (NPP), had a face-to-face encounter with the patient. The 2011 final rule required that the face-to-face encounter be related to the primary reason for the home health services, and occur no more than 90 days prior to the start of home health care, or within 30 days of the start of that care. The physician must also include a narrative explanation that the patient meets the criteria for coverage.

In the final rule, CMS updates results of its monitoring of home health utilization, and reports that it found variation in use by state (Texas, Florida, Oklahoma, Mississippi, and Louisiana are among the highest use states). However, CMS notes that overall home health users declined as a percent of all Medicare beneficiaries, and average number of episodes per beneficiary also declined. As in the proposed rule, CMS notes that, while a number of factors could be associated with the observed changes, it believes that implementation of the face-to-face requirement “could be considered a contributing factor.” As a result, CMS finalizes a change in the face-to-face encounter requirements.
Changes to the Face-to-Face Encounter Requirements

Background
In reviewing the regulatory background and implementation of the face-to-face requirement, CMS notes that the majority of past improper home health payments were due to “insufficient documentation” errors, and most of those errors occurred when the required narrative portion of the face-to-face documentation did not sufficiently describe how the clinical findings from the encounter supported the beneficiary’s homebound status and need for skilled services.

CMS notes that home health providers have expressed concern about the documentation requirement, notably the required narrative, as well as frustration with having to rely on physicians who may not have the same incentives to support compliance. The industry has been particularly concerned because the required narrative duplicates evidence available in the medical record that supports the physician’s certification.

Changes to Face-to-Face Narrative Requirement and Non-Coverage of Associated Physician Certification/Re-Certification Claims
CMS finalizes three changes to simplify the face-to-face encounter regulations without modifications.

- The requirement for a narrative is eliminated in most cases, beginning January 1, 2015. The physician will still be required to meet other standards: to certify that a face-to-face encounter related to the primary reason the patient requires home health services occurred no more than 90 days prior to or within 30 days of the start of care, and was performed by a physician or allowed non-physician practitioner, and the physician must document the date of the encounter. In cases where the physician is ordering skilled nursing visits for management and evaluation of the patient’s plan of care, the physician will still be required to include a brief narrative that describes the clinical justification of this need as part of the certification/re-certification.

- CMS will review only the medical record for the patient from the certifying physician or acute/post-acute facility used to support the physician’s certification in determining the patient’s eligibility for home health services.

- Physician Part B claims for certification/recertification will not be covered if the HHA claim itself is non-covered because the certification/recertification is not complete or because there was insufficient documentation to support the patient’s eligibility. This proposal would be implemented in sub-regulatory guidance.

CMS believes that these proposals are responsive to the industry’s concerns and invites comments.

Proposed Clarification When Documentation of a Face-to-Face Encounter is Required
CMS finalizes its proposal to clarify that the face-to-face encounter requirement is applicable for certifications, not recertifications. CMS modifies an earlier response provided in sub-regulatory guidance that stated the requirement applied to “initial episodes,” which are the first in a series of episodes separated by no more than a 60-day gap. Additionally, CMS clarifies that patients discharged following the completion of their HH plan of care, who are subsequently readmitted to the HHA during the same 60-day period, are required to be newly certified, not recertified.

Proposed Change to the Therapy Reassessment Time Frames
Current regulations call for therapy reassessments to be performed on or close to the 13th and 19th therapy visits, and at least once every 30 days, by a qualified therapist in the discipline(s) for the type of therapy being provided.
As in the proposed rule, CMS reviews the utilization data and reports on concerns voiced by HH providers about the timing of reassessments, especially the timing when multiple disciplines of therapy are being provided.

CMS finalizes its proposed changes to this policy with modification. In the proposed rule, CMS proposed to simplify the policy by eliminating the current requirements for reassessments at or close to the 13th and 19th therapy visits, and instead require that a qualified therapist from each discipline provide the needed therapy service and functionally reassess the patient at least every 14 calendar days. Many providers, including CHA, commented that the four-day interval would be too frequent. In response, CMS revised its policy to provide for a 30-day interval, and notes that this time frame was supported by the majority of commenters and aligns with many state practice acts.

Accordingly, CMS finalizes its proposal to eliminate the therapy reassessments that are required to be performed on or “close to” the 13th and 19th therapy visits. CMS is finalizing that a qualified therapist (instead of an assistant) from each therapy discipline provided reassess the patient at least once every 30 calendar days. Therapy reassessments are to be performed using a method that would include objective measurement, in accordance with accepted professional standards of clinical practice, which enable comparison of successive measurements to determine the effectiveness of therapy goals. The measurement results and corresponding effectiveness of the therapy must be documented in the clinical record.

**Implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)**

The Protecting Access to Medicare Act of 2014 (PAMA) delayed the transition to ICD-10 Code Sets to no earlier than October 1, 2015. HHS announced on May 1, 2014, that it intends to issue an interim final rule to require the use of ICD-10 beginning October 1, 2015, and will continue to require use of ICD-9 until that date.

Since the release of the CY 2015 HH PPS proposed rule, HHS has finalized the new compliance date of ICD-10-CM and ICD-10-PCS. CMS plans to disseminate more information about the transition from ICD-9-CM to ICD-10-CM through its HHA center website, the Home Health, Hospice and DME Open door forum, and in future rulemaking.

**Medicare Coverage of Insulin Injections**

CMS reviews Medicare coverage of insulin injections under the HH PPS. Coverage of home health visits for the sole purpose of insulin injections is limited to patients who are physically or mentally unable to self-inject and who have no other person willing and able to inject them.

CMS found that secondary diagnoses did not support that a patient was physically or mentally unable to self-inject on a substantial number of home health claims. It presents in Table 28 in the proposed rule (pages 38404-38406) a list of conditions that would support the need for ongoing home health nursing visits for insulin injection assistance for instances where a patient is physically or mentally unable to self-inject. CMS “…expects the conditions included in Table 28 to be listed on the claim and OASIS to support the need for skilled nursing visits for insulin injection assistance.”

In the proposed rule, CMS did not advance any policy changes, but solicited comments on the conditions listed. CMS notes that it plans to continue to monitor claims, and reiterates that “…evidence in the medical record must support the clinical legitimacy of the secondary condition(s) and resulting disability that limit the beneficiary’s ability to self-inject.”
Home Health Quality Reporting Program (QRP)
As in the proposed rule, CMS reviews background on the HH quality reporting program, changes implemented in the 2014 final rule, the Outcome and Assessment Information Set (OASIS) used for HHAs, and the pay-for-reporting program implemented in 2007, under which the market basket percentage increase is reduced by two percentage points for HHAs that do not report required quality data.

“Pay-for-Reporting” Performance Requirement for Submission of OASIS Quality Data
CMS again notes that the quantity of OASIS assessments each HHA must submit to meet the pay-for-reporting standard has never been proposed or finalized through rulemaking or through the sub-regulatory process. CMS adopts as final its proposal to establish a pay-for-reporting performance requirement, with modifications to the proposed phase-in schedule. The final rule adopts standards and a formula for phasing in requirements for a “data completeness standard” for OASIS assessments.

The finalized standards include a performance system that CMS describes as “driven by the principle that each HHA would be expected to submit a minimum set of two ‘matching’ assessments for each patient….” These matching assessments create what CMS would consider a “quality episode of care” that would ideally consist of a Start of Care (SOC) or Resumption of Care (ROC) assessment and a matching End of Care (EOC) assessment (an EOC assessment can be conducted on transfer to an inpatient facility, with or without discharge, death or discharge from HH care). However, in addition to this ideal situation, CMS spells out several scenarios that could meet the “matching assessment” requirement to meet the definition of a “quality assessment” in the formula below to create a quality episode.

- An SOC or ROC assessment that has a matching EOC assessment. The two assessments create a regular quality episode of care and both count as quality assessments.
- An SOC/ROC assessment that could begin an episode of care, but occurs in the last 60 days of the performance period. This is labeled a “Late SOC/ROC” quality assessment.
- An EOC assessment that could end an episode of care that began in the previous reporting period (an EOC that occurs in the first 60 days of the performance period). This is labeled an “Early EOC” quality assessment.
- An SOC/ROC assessment followed by one or more follow-up assessments, the last of which occurs in the last 60 days of the performance period. This is labeled a “SOC/ROC Pseudo Episode” quality assessment.
- An EOC assessment preceded by one or more follow-up assessments, the last of which occurs in the first 60 days of the performance period. This is labeled an “EOC Pseudo Episode” quality assessment.
- An SOC/ROC assessment that is part of a known one-visit episode. This is labeled a “One-visit episode” quality assessment.

SOC, ROC, and EOC assessments that do not meet any of these definitions are labeled “nonquality” assessments. Follow-up assessments are considered “neutral” assessments and do not count for or against the pay-for-performance requirements in the QAO formula, described below.

CMS proposed a “Quality Assessments Only” (QAO) formula to measure performance. Only those OASIS assessments meeting one of the standards above would be counted as a “quality assessment.” SOC, ROC and EOC assessments not meeting one of the standards would be counted as a “nonquality assessment.” The formula expresses the percentage of quality assessments, as follows:
QAO = \frac{(# \text{ of quality assessments})}{(# \text{ of quality assessments plus } # \text{ of nonquality assessments})} \times 100

CMS noted that its ultimate goal is to require all HHAs to achieve a pay-for-reporting performance standard of 90 percent, using this QAO metric, but proposes to implement it incrementally over a three-year period, beginning with the reporting period for all episodes of care that occur on or after July 1, 2015. The following table sets out the proposed and final phasing schedule.

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>QAO performance standard</th>
<th>Proposed phase-in schedule</th>
<th>Final phase-in schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes beginning on or after July 1, 2015 and before June 30, 2016</td>
<td>70%</td>
<td>2017</td>
<td>2017</td>
</tr>
<tr>
<td>Episodes beginning on or after July 1, 2016 and before June 30, 2017</td>
<td>80%</td>
<td>2018</td>
<td>Deferred, but likely to be 80% or higher, not to exceed 90%</td>
</tr>
<tr>
<td>Episodes beginning on or after July 1, 2017 and before June 30, 2018</td>
<td>90%</td>
<td>2019</td>
<td>Deferred, but likely to be 80% or higher, not to exceed 90%</td>
</tr>
</tbody>
</table>

As noted above, the final rule includes the following modifications:

- For episodes beginning on or after July 1, 2015, and before June 30, 2016, HHAs must score at least 70 percent on the QAO metric of pay-for-reporting performance requirement or be subject to a two percentage point reduction to their market basket update for CY 2017.
- CMS is deferring for now setting a minimum OASIS reporting requirement for the second and subsequent years of the OASIS “pay-for-reporting” performance requirement program. However, CMS will monitor provider performance and consider increasing the requirement in subsequent years. CMS anticipates rates of at least 80 percent or higher, not to exceed 90 percent, in years two and three.

Updates to HH QRP Measures Made as a Result of Review by the NQF Process
CMS reiterates its proposed rule review of the process of adopting measures and the role of the National Quality Forum (NQF). CMS finalizes its proposals:

- If the NQF updates an endorsed measure that CMS has adopted for the HH QRP in a manner that CMS considers not to substantially change the nature of the measure, CMS would use a sub-regulatory process to incorporate those updates to the measure specifications that apply to the program. CMS would do this by revising the information posted on the CMS Home Health Qual-

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1 A reporting period is defined as the submission of OASIS assessments for episodes between July 1 of the calendar year two years prior to the calendar year of the annual payment update (APU) effective date, through the following June 30 of the calendar year one year prior to the APU effective date.
CMS moves to finalize this proposal, and continues to believe that it balances the need to incorporate NQF updates to NQF-endorsed measures in the most expeditious manner possible while preserving the public’s ability to comment on updates to measures with substantial changes. CMS notes that it has adopted a similar policy for the Hospital IQR program and other programs.

In response to comment about the importance of educating HH providers about the new OASIS data submission requirements, CMS says that prior to and during the initial performance period of July 1, 2015 through June 30, 2016, it will schedule multiple Open Door forums and webinars to educate HHA personnel about the pay-for-reporting performance requirement program and QAO metric. Additionally, OASIS education coordinators (OECs) will be trained to provide state-level instruction.

Home Health Care CAHPS® Survey (HHCAHPS)
In the proposed rule, CMS reviewed background on the development and implementation of the Home Health Care Consumer Assessment of Health Providers and Systems (HHCAHPS) Survey, and proposed no changes to the HHCAHPS requirements at the current time.

HHA Value-Based Purchasing Model
As in the proposed rule, CMS reviews Medicare’s value-based purchasing (VBP) programs and its “Report to the Congress on VBP in Medicare Home Health.” In the proposed rule, CMS asked for comments on a HHA VBP model, building on what it has learned from the hospital VBP program. CMS sees this model as an opportunity to test whether larger incentives will lead to even greater improvement in the quality of care. If implemented, the model would begin in 2016 under CMS’ section 1115 demonstration authority. CMS projects that it would operate in five to eight states selected to participate, and is considering a model in which participation by HHAs in those states would be mandatory.

In the final rule, CMS summarizes the comments it received, in particular concerns about the magnitude of five to eight percent payment adjustment incentives, as well as comments on the evaluation criteria under the model, and selection of states and HHAs for participation.

CMS says that it will consider these comments as it makes further decisions about implementing a HHA VBP model in CY 2016, which would assess performance from each of the preceding baseline years, and restates its intention to invite additional comments on a more detailed model proposal in future rulemaking.

For Additional Information
For more information, please contact Pat Blaisdell, CHA vice president, post-acute care, at (916) 552-7553 or pblaisdell@calhospital.org; or Alyssa Keefe, CHA vice president, federal regulatory affairs, at (202) 488-4688 or akeefe@calhospital.org.
December 5, 2014

Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201


Dear Administrator Tavenner:

On behalf of the California Hospital Association (CHA) and our nearly 400 member hospitals and health systems, including more than 100 hospital-based and health system-operated freestanding home health agencies (HHAs), we are pleased to submit comments regarding the Centers for Medicare & Medicaid Services’ (CMS) proposed rule updating the Medicare and Medicaid conditions of participation (CoPs) for HHAs. CHA-member HHAs provide care to over 200,000 Californians annually and play a critically important role in the continuum of care.

CHA appreciates CMS’ continued focus in revising the conditions of participation for all entities, including HHAs. As our health care delivery system continues to transform, the CoPs must continue to support this important transformation and eliminate unnecessary regulatory barriers that only add administrative costs to the system and limit an HHA’s ability to devote limited resources to direct patient care. California’s hospital-based and health system-operated free-standing HHAs play a critically important part in the continuum of care and, as such, are integral to the success of our patients receiving the care they need. At the same time, high-quality home care decreases the likelihood of a hospital admission or readmission, and keeps beneficiaries in their homes where they can continue to remain independent.

We appreciate CMS’ attention to moving away from process-oriented survey approaches to a more comprehensive outcomes-focused approach. In doing so, in the proposed rule, CMS has provided much-needed flexibility that will allow for the HHA to take necessary steps to ensure that the patients served can achieve the highest quality outcomes.

Generally, CHA supports the direction and intent of CMS’ proposed revisions to the HHA CoPs. We believe the goals CMS has put forward are achievable, but we are concerned that a number of provisions would require additional time to implement and successfully operationalize. We detail areas of greatest concern in our comments below.

Most importantly, we understand from our HHAs that in order to successfully comply, HHAs need additional time to make changes, train staff and streamline their operations. Our members believe CMS has understated the time and resources it will take to make some of the more significant changes. Therefore, CHA urges CMS to allow HHAs one year from the date of the final rule for the finalized
CoPs to be effective. During this time, we encourage CMS to continue its work with stakeholders in developing the State Operations Manual (SOM) guidance that will provide needed clarifications to ensure successful implementation. Key to success is a shared understanding of the requirements of each CoP by providers, accrediting organizations and state survey agencies. While we appreciate the overall framework of many of these requirements, the lack of specificity in how an HHA would appropriately comply is of concern to CHA and our HHAs. We believe a balance can be forged between the need for flexibility and specificity. Too much of either often leads to variation in interpretation and implementation, and subsequent erroneous survey findings.

Due to continued state surveyor variability in interpreting CMS guidance, we ask CMS to make available training for all interested parties to facilitate a shared understanding and interpretation of the CoPs. While we understand the need for CMS to remain an independent regulatory body, CMS also has a responsibility to promote a shared understanding by all parties of the expectations for HHA CoP compliance. Creating a transparent process in the development of SOM guidance, making available additional educational resources and delaying the effective date are critical to successful implementation and compliance.

Our detailed comments are discussed below:

Patients’ Rights (§484.50)
Under the proposed rule, the requirements for patient rights would be reorganized and would include the following: a) Notice of Rights: how the patient will be informed about his/her rights; b) Exercise of Rights: who may exercise the rights of the patient; c) Rights of the Patient: a numerical listing of 12 patient rights; d) Transfer and Discharge: criteria for the transfer/discharge of patients; e) Investigation of Complaints: what types of complaints must be investigated, responsibilities of HHAs and staff; and f) Accessibility: how information must be provided to persons with disabilities and limited English proficiency.

CHA supports the intent of these provisions in safeguarding that patients are both aware of their rights and engaged in their plan of care. Our HHAs point out, however, that the growing list of requirements of information to convey to patients on their first visit — in particularly elderly Medicare patients with limited cognitive abilities — will be overwhelming. Moreover, there was concern expressed that the especially critical information on how to make a complaint may get lost in the “morass of paperwork” provided to the patient. CHA asks CMS to consider allowing some flexibility in the timing of the information provided. While we agree all the information is critically important and must be provided to the patients in a way they can understand, we do believe that there are some patients who may need to have this information presented over more than one visit. HHAs would still be responsible for documenting that the information has been provided, but allowing for flexibility in timing is important. For example, the HHA may prioritize the notice of rights and rights of the patient complaint information in one visit, and in the next visit provide information regarding transfer and discharge criteria.

In addition, HHAs expressed concern that CMS has underestimated the costs of providing all of the information in a language or form in which the patient (or caregiver) or a patient with disabilities may be able to understand. These services are costly and, unfortunately, not adequately captured in the payment by Medicare or other payers. The diversity of the patient population continues to grow. In many markets in California, more than 100 languages and dialects may be spoken. As the use of technology improves our ability to communicate effectively, we anticipate additional access to translation services through platforms like iPhone apps that would decrease the costs. We encourage CMS to acknowledge in the
final rule the technology that could be brought to bear in achieving the accessibility requirement so as to
not promote older, more costly ways of operating.

**Care planning, coordination of services and quality of care (§484.60)**

This proposed new CoP would reorganize, and in some cases, substantially revise existing standards involving the plan of care, conformance with physician orders, review and revision of the plan of care, coordination of care and discharge transfer summary. In particular, the requirements for the individualized plan of care would be specified at §484.60(a), and would include patient-specific measurable outcomes.

With regard to the plan of care, CMS discusses and cites literature regarding the benefits of using a shared decision-making model and is particularly interested in methods to engage patients and physicians in care planning and management processes. At §484.60(c), modified requirements are proposed for updating the individualized plan of care. In particular, new requirements are proposed for communicating with the patient, representative, caregiver and responsible physician about changes to the plan of care or patient discharge.

In discussing these new provisions with HHAs, we agree that patient and physician engagement is critical in achieving a positive outcome. With that said, the proposed rule requires HHAs to both educate patients and caregivers on the plan of care and communicate to patients and provide them with a copy of the plan of care each time it is updated. A couple of concerns arise in the wording of the regulation. CHA supports the intent of the proposed changes, but asks for additional clarification.

For example, operationally, HHAs are concerned that CMS assumes the current plan of care will be understandable to patients as currently written. The current plan of care audience is the physician and other clinicians providing patient care, and the HHA. The information contained in the current plan of care is not likely easily understood by patients and, perhaps, may be difficult to communicate. **CHA asks CMS to consider allowing, but not requiring HHAs to provide, when appropriate, a more accessible form of the plan of care to meet the needs of the audience — the patient.** This would not substitute the required clinical plan of care that physicians and the HHA need to effectively communicate. Rather, this more accessible information would complement existing information to help facilitate understanding and the educational process. HHAs should be afforded the flexibility, when appropriate, to provide such information at their discretion so long as the actual plan of care is still provided. We anticipate providers would adopt operational strategies to document receipt in the record and facilitate understanding of the communication related to the plan of care.

Notably, there are several ways an HHA may choose to communicate such information, and allowing the flexibility for HHAs to efficiently provide that information to patients is important.

Finally, CHA asks that CMS consider allowing HHAs some flexibility in communicating changes to decrease the complexities of such communications. For example, for medically complex patients, we anticipate their plans of care may change more frequently and some changes may be more significant than others — such as the change in the frequencies of visits versus a change in therapy from physical to occupational therapy, with new caregivers coming to the home. Another example is a change in medication dose versus a change in medications. For some of the more frequent and less significant changes, CHA asks CMS to strongly consider allowing flexibility in communicating these changes to patients to limit potential confusion.
Further, hospital-based HHAs are moving toward the expanded use of an electronic health record (EHR). Stage II of meaningful use puts additional emphasis on access to a patient portal. CHA urges CMS to acknowledge and allow for the accessibility of the plan of care through a patient portal by the patient or the caregiver, if available, to meet the requirement for sharing the plan of care with the patient. Having the plan of care reside in the EHR would also facilitate the collaboration and coordination in care management between the physician and HHA. CHA appreciates that we have variation in the adoption of EHRs across the state and the nation, and that many organizations are not yet able to share a plan of care through the patient portal. Many of our members noted that they will need to rely on providing a paper copy via mail or hand-delivered by a caregiver to meet this requirement. For our more medically complex patients, with frequent changes in their plan of care, we believe CMS has underestimated the cost and time it will take for HHAs to streamline this process to ensure its efficiency.

The final standard in this section is proposed at §484.60(e), requiring a discharge or transfer summary be compiled for each discharge or transfer. The proposed standard specifies the content to be included in these documents. CHA supports these requirements but has some concerns related to the HHA’s responsibilities regarding dissemination of the summaries discussed in §484.110.

Specifically, the proposal would require the HHA to provide the summary within seven calendar days to the professional who will be responsible for providing post-discharge care, and within two calendar days to a facility in the case of patients discharged to a health care facility.

CMS seeks input on whether the proposed time frames are adequate to assure a smooth transition of care and whether current HHA record systems are capable of producing a discharge summary in a shorter period of time, such as the same day a patient is discharged. In discussing this provision with our HHAs, a number of operational issues were identified. First, HHAs would ask that CMS specify business days rather than calendar days. For many of our agencies, the medical records may be managed by the hospital’s health information management department, which is often closed on weekends.

Second, and most importantly, while we agree that information should be provided as soon as possible and that HHAs should make every effort to provide timely information upon transfer or discharge, the clock must start when the HHA is notified of the patient being transferred to a facility. Or rather, we recommend the regulation should stipulate these time frames for one of the “planned discharges or transfers” noted in the regulation at §484.50 (d). Often, during an episode of home care, the patient may experience an acute episode that requires ambulance transport to a hospital and the patient effectively is discharged from the home health agency, as care has now continued with a new provider. It may be several days before an HHA is notified of such event, as that patient may not be scheduled for care on a daily basis. The Medicare policy manual stipulates that the home health agency may chose when to discharge the patient, but it may not be planned and therefore additional time is needed to comply.

Finally, HHAs report that many of their patients may be cared for by a group practice, rather than one physician. We would ask that CMS consider clarification in the regulation that acknowledges notification to a physician or group practice to be more inclusive of how care is being delivered in a multi-disciplinary team setting and or medical home.
Quality Assessment and Performance Improvement (§484.65)

CMS proposes a new CoP implementing Quality Assessment Performance Improvement (QAPI) programs that would replace existing standards pertaining to professional personnel advisory and evaluation roles. CHA supports the elimination of the professional advisory panel and subsequent evaluation roles.

The proposed QAPI CoP would have standards related to (1) program scope; (2) program data; (3) program activities; (4) performance improvement projects; and (5) executive responsibilities. CMS emphasizes that the proposal would require HHAs to undertake proactive ongoing quality improvement, whereas current standards involve external after-the-fact assessment. The HHA’s governing body would be responsible for the QAPI program, which would measure, analyze and track quality indicators.

CHA appreciates and supports CMS’ affirmation and encouragement in allowing HHA flexibility in designing data collection and analysis procedures that meet the needs of their patient population. Many of the requirements that focus on identifying and correcting high-risk, high-volume, or problem-prone areas are consistent with HHA accreditation requirements of The Joint Commission (TJC). The vast majority of hospital-based HHAs in California are accredited by TJC and are familiar with similar requirements. CHA supports CMS’ efforts to implement QAPI programs for HHAs.

Further, CMS proposes HHAs measure and document results of its QAPI program activities. CMS notes that surveyors would assess whether all components of the QAPI program were in place, and would also expect HHAs to demonstrate, using QAPI program data, that improvements took place in care outcomes, patient satisfaction, processes of care or other quality indicators. As this is a new area for surveyors to review, CHA urges CMS to consider a similar approach of the use of development of pilot tools that can be shared with both providers and surveyors to provide additional guidance and expectations. CHA and our member HHAs would be willing to engage with CMS in the process of developing and testing such a tool. Finally, while much of the focus has been on patient outcomes, we believe that the sentiments expressed in the rule also acknowledge the need for care that would allow the patient to remain in their home. This may or may not result in what is typically measured or considered when discussing improvements in activities of daily living and functional status.

In conclusion, CHA supports many of the provisions outlined in the proposed rule, but additional clarification and changes are needed to promote shared understanding and efficiencies in providing this care. As previously stated, our members believe CMS has underestimated the time and resources it will take to implement some of the more significant changes. CHA urges CMS to allow HHAs one year from the date of the final rule for the finalized CoPs to be effective. If you have questions, please do not hesitate to contact me at akeefe@calhospital.org or at (202) 488-4688.

Sincerely,

/s/
Alyssa Keefe
Vice President, Federal Regulatory Affairs
January 28, 2015

TO: Center for Post-Acute Care Advisory Board

FROM: Patricia Blaisdell, VP, Post-Acute Care Services

SUBJECT: LTCH Provider Update

SUMMARY

Long-Term Acute Care Hospitals (LTCHs) are members of the CHA Center for Post-Acute Care.

ACTION REQUESTED

➢ To provide attendees an update regarding issues impacting long term acute care hospitals (LTCHs).

DISCUSSION

A. Quality Indicators

Members of the forum provided input on proposed quality indicators under consideration by the Measures Application Partnership (MAP). The MAP, convened by the National Quality Forum, will review the list and provide recommendations to CMS for their consideration for adoption in future rulemaking. Pamela Roberts, Ph.D., from CHA member hospital Cedars-Sinai Medical Center, is a member of the MAP. Based on the input received, CHA submitted comments regarding the proposed measures.
January 28, 2015

TO: Center for Post-Acute Care Advisory Board
FROM: Tracy Campbell, Vice President, Digital Advocacy

SUBJECT: CHA Digital Advocacy

SUMMARY

Tracy Campbell directs CHA’s Public Advocacy Program, which seeks to educate, inform and influence target audiences on health care access issues, including the cost of delivering services.

ACTION REQUESTED

➢ To provide an update on CHA digital advocacy plan and the Our Health California community

DISCUSSION

In its first year, the Our Health California (OHC) digital advocacy campaign grew to exceed its goals, creating a new and engaged community of health care advocates. The OHC digital community, with more than 380,000 people, is committed to protecting and advancing safe, high-quality health care for all Californians. In 2014, digital community members participated in important advocacy efforts including the defeat of AB 503, a top priority for CHA in 2014, as well as passage of Proposition 1, California’s water bond measure. OHC, sponsored by CHA, will continue to grow its community in 2015 and tell the important story of California’s unique role as a health care leader.

Attachments Our Health California flyer
Real people.

Our community is full of people just like you - people who care for their children, their parents, or their patients. People who understand the importance of access to quality health care. People who are willing to take a stand to protect what matters most: our health.

Real stories.

The Our Health California community is built on authentic stories. Help us share the great work done in your communities every day - just scan the code below and answer a few short questions about the story you want to tell. Why is it compelling? What makes it unique?

Real impact.

From protecting access to safe drinking water, to ensuring community benefit programs keep their funding, our community rallies around important issues.

Let’s get started.

For more information, please contact Tracy Campbell, CHA’s vice president, digital advocacy, at (916) 552-7594 or tcampbell@calhospital.org.
January 28, 2015

TO: Center for Post-Acute Care Advisory Board

FROM: Patricia Blaisdell, Vice President, Post-Acute Care Services
       Alyssa Keefe, Vice President, Federal Regulatory Affairs.

SUBJECT: Federal Affairs Update

SUMMARY

Regulatory and legislative activities at federal level have significant implications for CHA member post-acute care providers.

ACTION REQUESTED

➢ To provide an update regarding federal legislation of concern to CHA members and providers of post-acute care services
➢ To provide an update regarding federal regulatory activity of concern to CHA members and providers of post-acute care services

DISCUSSION

Current legislative and regulatory issues will be reviewed and discussed, with an emphasis on implications for hospitals and for hospital and health system post-acute care providers, and the identification of recommended actions.

Federal legislation
On Oct. 6, President Obama signed into law the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The bipartisan bill was designed to increase quality, transparency and accountability in post-acute care for Medicare beneficiaries. The Act would require post-acute care providers — including long-term acute care hospitals, inpatient rehabilitation facilities, skilled-nursing facilities and home health agencies — to collect and report standardized assessment data as a first step in developing recommendations for alternative post-acute care payment models. Additionally, the legislation includes new survey and medical review requirements for hospices. These provisions will be implemented between 2016 and 2022.
**Federal Regulation**

CHA maintains a full-time presence in Washington, D.C., to effectively advocate on legislative and regulatory policy, and collaborates on policies and strategies for health care issues with the American Hospital Association and other national health care organizations. On behalf of members, CHA provides input on developing federal legislation and regulatory proposals, and helps shape national positions on important health care issues.

**Attachments**

- IMPACT Act of 2014 PPT
- Regulatory Outlook
- RAC Updates
The IMPACT Act of 2014
“Standardizing post-acute care assessment data for quality, payment and discharge planning and for other purposes.”
Why the IMPACT Act?

Utilization of PAC accounts for a significant portion of Medicare-paid services, and is growing rapidly.

PAC utilization patterns and associated costs vary widely between regions.

While post-acute care provider types treat patients of similar diagnoses, each has a different payment system and patient assessment instrument.

Post-Acute Care

Medicare post-acute care includes four distinct provider types:

1. Inpatient Rehabilitation Facilities (IRFs)
2. Long Term Acute Care Hospitals (LTCHs)
3. Skilled Nursing Facilities (SNFs)
4. Home Health Agencies (HHAs)
Post-Acute Care

PAC and LTC are often provided side by side, either at home or in an institutional setting.

Post-Acute Care
Episodic
Medical Focus
Primary Payer - Medicare

Long Term Care
Ongoing
Residential Focus
Primary Payer – Medi-Cal

Utilization of PAC accounts for a significant portion of Medicare-paid services, and is growing rapidly.

43% — the proportion of Medicare patients discharged to post-acute care.

23% — the portion of total Medicare dollars spent on post-acute care

8% + — the annual rate at which Medicare spending grew from 2001-2012

Source: Gage, et al. Examining post-acute relationships in an integrated hospital system, ASPE, 2009
Post-Acute Care

PAC utilization patterns and associated costs vary widely between regions.

- PAC per capita costs vary by state:
  - OR: <$1,401
  - CA: $1,401 - $1,566
  - TX: > $1,896

- PAC accounts for 73% of Medicare regional spending variation.


Post-Acute Care

Source: RTI/Cain Brothers Analysis, "Integrating Acute and Post-Acute Care", 2012
### Post-Acute Care

<table>
<thead>
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<td>Per diem</td>
<td>Per 60-day episode of care</td>
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<tr>
<td>Case-mix adjuster</td>
<td>Diagnosis - Related Groups specific to LTCH patients (LTMS-DRG)</td>
<td>Case Mix Groups (CMD)</td>
<td>Resource Utilization Groups (RUGs)</td>
<td>Home Health Resource Groups (HHRGs)</td>
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<td>Setting-specific Requirements</td>
<td>25% referral rule, GACH ICU stay + vent care needs, “Site-neutral” payment for certain DRGs</td>
<td>60% diagnosis rule, 3 hour therapy “rule” Rehab MD oversight and care coordination</td>
<td>Skilled need 3-day qualifying stay</td>
<td>Homebound status “Face-to-Face” certification of skilled care need</td>
</tr>
</tbody>
</table>

**Extended medical care for patients with complex medical needs and multiple conditions.**

- **ALOS:** > 25 days
- **ALOS:** 2 – 3 weeks
- **ALOS:** 2 – 3 weeks for transitional care
- **Average # visits:** 18 – 20
- **$38,664/case (2011)**
- **$17,398/case (2011)**
- **$12,200/case (2011)**
- **$2,815/case (2010)**
- **10% 30-day GACH readmission rate (2011)**
- **19.2% 30-day GACH readmission rate (2011)**
- **28% 30-day GACH readmission rate (2009)**

Source: MedPAC Report to Congress, March 2013

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### PAC Payment System

While post-acute care providers treat patients of similar diagnoses, each has a different payment system and assessment instrument.

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Provisions of the IMPACT Act

Patient Assessment

• Requires PAC providers to report standardized patient assessment data at admission and discharge beginning October 1, 2018.

• To include functional status, cognitive function, medical needs and conditions, special services, prior functioning, and others as deemed necessary.

• Requires to the extent possible that these items replace existing similar items in each data set.

Provisions of the IMPACT Act

New Quality Measures

• Requires the identification and reporting of additional quality measures beginning October 1, 2016.

• To include functional status and change in function, skin integrity, medication reconciliation, incidence of major falls, and patient preference and discharge options.

• Provides for feedback reports, public reporting, and payment consequences for failure to report.
Provisions of the IMPACT Act

Resource Use Reporting

• Requires provider reporting on resource use beginning October 1, 2016.

• To include Medicare spending per beneficiary, discharge to community, risk-adjusted hospital readmissions.

• Requires the Secretary of HHS to align claims data with patient assessment data beginning October 1, 2018.

Provisions of the IMPACT Act

Discharge Planning

• Requires a review of the value of standardized data collection in the GACH setting.

• Requires by January 1, 2016, that conditions of participation for acute hospital and PAC providers take into account quality and resource use measure to “inform” discharge planning.

• Specifies that the Act does not require an individual to be provided care by a specific type of provider.
### Provisions of the IMPACT Act

#### Quality measure timeline

<table>
<thead>
<tr>
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<tr>
<td>Quality measure – skin integrity</td>
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<td>Quality measure – cognitive function and functional status</td>
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<td>Quality measure – major falls</td>
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<td>Quality measure – medication reconciliation</td>
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<td>Quality measure – care preference</td>
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<td>Resource Use and other measure.</td>
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<td>1/01/2017</td>
</tr>
</tbody>
</table>

Chart shows data collection and reporting deadlines – Feedback reporting and public reporting is required one and two years, respectively, after the noted dates.

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### Provisions of the IMPACT Act

#### MedPAC/PAC-PRD Report

Requires MedPAC to use data from the PAC-PRD and submit a report to Congress that evaluates and recommends features of a PAC payment system establishing payment rates according to patient characteristics instead of care setting by June 30, 2016.
Provisions of the IMPACT Act

Technical Prototype

Requires HHS and MedPAC to provide recommendations and a technical prototype for a system based on patient characteristics, two years after the collection of two years of quality data.

Must include recommendations on which Medicare regulations should be modified.

Socioeconomic Impact

Requires HHS to study the effect of socioeconomic status and risk factors such as race, health literacy, and limited English proficiency on quality and resources, and to make recommendations on how to account for such factors in payments.
Hospice

The IMPACT Act also includes provisions affecting hospice services.

- Requires standard surveys no less than every 36 months.
- Implements medical review as a condition for care provided to a patient more than 180 days for hospices with a designated proportion of such patients.

Implications

The IMPACT Act will require significant operational changes at all care settings within the near future.

- Changes to patient assessment in all settings
- Potential impact on payment
- Increased quality reporting
- Development of new protocols to address new requirements.
Implications

In the long term, the provisions of The IMPACT Act will promote far-reaching and dramatic changes to our health care delivery system and reimbursement.

- Site-Neutral payment
- Bundled payment
- Episodic and outcome-based payment models
- Quality management
- Value of care vs. volume of care

Implications

The IMPACT Act underscores the important role of post acute care in health care reform.

Effective use of PAC services will:
- Support acute care LOS management
- Prevent unnecessary hospital readmissions
- Promote optimal functional outcome
- Control episode cost of care
- Require partnerships across the continuum
Health care reform changes/expands the focus of payment & policy

Current Focus Areas

Past Focus Areas

Purpose:

- Represent and support hospital-based post-acute providers
- Foster communication and collaboration among and between member PAC provider groups
- Serve in an advisory capacity to the CHA Board of Trustees

The CHA Center for Post-Acute Care was created in 2011
Questions?

Thank you!

**Pat Blaisdell**  
*Vice President, Post-Acute Care Services*  
CHA  
[pblaisdell@cathospital.org](mailto:pblaisdell@cathospital.org)  
(916) 552-7553
January 20, 2015

TO: Center for Post-Acute Care Advisory Board
FROM: Alyssa Keefe, Vice President Federal Regulatory Affairs
SUBJECT: Federal Regulatory Updates and the 2015 Look Ahead

Below is a brief summary of a number of issues that CHA is monitoring and actively engaged in that are of interest to the CHA Center for Post-Acute Care. We invite you to share your thoughts or comments on other federal issues of interest for future discussion. Questions regarding this report can be sent to me at akeefer@calhospital.org. I look forward to the board discussion on January 28.

RAC Program Updates

In late December, the Centers for Medicare & Medicaid Services (CMS) released a summary of program updates (Attachment A) to the recovery audit contractor (RAC) program. While many were previously released at the beginning of the rebid process, there were a few updates in this release. Among the changes to the program, CMS will limit the RAC look-back period for patient status reviews to six months after the date of service if the hospital has submitted its claim within three months of the date of service. In addition, CMS notes that it will provide the RACs with 30 days — rather than 60 — to issue the review results letter. This was further articulated in a Medicare transmittal that has set an effective date of February 24, 2015. CMS also notes the changes will be effective with each new RAC contract. Notably, on Dec. 30 CMS awarded the durable medical equipment contract to Connolly LLC. CMS notes the new RAC contracts for Regions 1, 2 and 4 remain under “a pre-award protest,” which is expected to continue well into 2015. Therefore, CMS has extended the current RAC contracts, without the new improvements noted above, through 2015. CHA expects HDI, California’s RAC, to ramp up its efforts early this year. While the scope of the audits are not yet clear under these extended contracts, HDI had approval to proceed with all previously approved automated reviews and diagnosis-related group validations.

CHA continues to work closely with the American Hospital Association to introduce federal legislation in the new Congress that would bring much-needed reforms to this program. Watch for a CHA advocacy alert in the coming weeks as we will be seeking support of cosponsors on any legislation that is introduced.

MedPAC Adopts Recommendations for 2016 Payment Updates

Calls for site-neutral payments for IRF and SNF care

The Medicare Payment Advisory Commission (MedPAC) has approved final recommendations for 2016 Medicare payment updates, which will be released in March. The recommendations are nearly identical to the commission’s 2015 recommendations, with some additions, and will be closely watched by Congress as it looks for savings to fund a long-term repeal of the Medicare sustainable growth rate for physician payments. A complete list of specific MedPAC recommendations follows.

Of particular to the Center are the hospital and post-acute care recommendations.

- Hospital inpatient and outpatient payments: MedPAC adopted its draft December recommendation and recommends a 3.25 percent increase for hospital inpatient and outpatient prospective payment systems (PPS) in 2015, noting that its recommendation is 5.25 percent if the sequester continues in 2016. MedPAC notes that even the most efficient hospitals it has identified will experience negative Medicare margins in 2016.
However, MedPAC also stands by its recommendation to Congress to reduce or eliminate payment differences between hospital outpatient departments and physician offices for 66 selected procedures. The commission also recommends Congress pay long-term care hospitals (LTCHs) the same rates as general acute care hospitals for cases involving patients who are not deemed “chronically critically ill” (CCI) — defined as an intensive care unit stay of at least eight days. Savings realized by cutting LTCH payments would be redistributed to create a new outlier pool for CCI cases treated in inpatient PPS hospitals. The LTCH policy would be phased in over three years.

Despite hospital opposition to the site-neutral recommendations noted above, MedPAC believes strongly in the principal that clinically similar patients can be seen in multiple provider settings and, as such, the payment rates should be equal. CHA has argued that both of these site-neutral recommendations are not only harmful to hospitals and patients, but that the analysis MedPAC engaged in setting forward these recommendations is outdated. Both the outpatient prospective payment system and LTCH PPS have adopted significant policy changes that have not been accounted for by MedPAC. CHA is very disappointed in the site-neutral recommendations.

- **Inpatient rehabilitation facilities and skilled-nursing facilities:** MedPAC finalized its recommendation to eliminate the payment update for SNFs and IRFs in 2016. MedPAC continues to call for a recalibration of the SNF PPS to pay more for medically complex patients and to rebase the payment system over a period of time. In addition, MedPAC has voted to recommend that Congress direct the Secretary to eliminate the differences in payment between IRFa and SNaF for selected conditions. While its analysis focused on 22 MS DRGs for consideration, MedPAC stepped back from its more specific draft recommendation and noted that the conditions should be selected by the Secretary and considered through a notice of public comment. MedPAC also notes that this policy should be implemented over three years and that the IRF would retain its current add on payments, but that the site-neutral payment should be set to the average SNF rate. Further, MedPAC recommends that regulations related to the 60 percent rule be reviewed and that such cases be removed from the threshold in order to remain compliant. The commission noted that while the payment would change in the IRF, this benefit would remain a Part A benefit and, therefore, subject to the same cost sharing as currently applied to the IRF stay.

- **Long-term care hospitals:** MedPAC finalized its recommendation to eliminate the payment update for LTCHs in 2016.

- **Home health:** The commission restated previous recommendations from 2011 and 2012 in reforming the payment system and recommends that Congress direct the Secretary to reduce payments for those with higher readmission rates than the benchmark rate that would be known in advance. The previous recommendations included reducing payments through a full “rebasing” of reimbursement. This month the commission adopted its recommendation to eliminate the update for FFY 2016.

- **Hospice:** The commission adopted its recommendation to eliminate the update for FFY 2016.

The presentations made by MedPAC staff at the January meeting, along with the meeting transcript, will be available on the MedPAC website at www.medpac.gov.

**CHA Submits Comments on MAP Recommendations for Future Quality Measures**

*MAP Coordinating Committee to Meet January 26 and 27 to Finalize Recommendations*

CHA has submitted comments (Attachment B) to the Measures Application Partnership (MAP) on its draft report to the Centers for Medicare & Medicaid Services (CMS) for measures under consideration for future federal rulemaking. While CHA is generally supportive of many of the recommendations in the
The comments provide a number of considerations for the National Quality Forum and CMS to improve the MAP process. CHA urges CMS to provide the list of measures under consideration in a more usable format and include links to the most recent revisions to the measure specifications so that stakeholders have as much information as possible before providing input on recommendations. CHA also requests that the measure rationale be specified for each setting for which the measure is being considered. CHA also requests additional transparency about the status of measures under development, and that the MAP further refine and prioritize measurement gaps to provide clear direction to CMS on measurement priorities. CHA's comments were developed from input gathered during three separate member calls held in December. The Coordinating Committee will consider the recommendations at its meeting on January 26 and 27. The MAP must submit its final report to CMS by Feb. 15.

CHA will attend the Coordinating Committee and provide an update on the final recommendations on the 28th.

**A Look Ahead at 2015 – The Regulatory Forecast**

This year will be a very busy year for post-acute care providers. Notably, CMS will need to take a number of steps to implement the recently enacted IMPACT Act which will take steps toward reporting patient outcomes across all post-acute care settings. Further, the work will set the stage for continued move toward a more aligned post-acute care payment system. In addition to the IMPACT Act, CMS will also need complete implementation to the LTCH PPS that were passed as part of the SGR Patch in 2014 and will take effect October 1. CHA anticipates fairly significant rulemaking in each of the post-acute care payment rules expected in 2015. As a reminder, the LTCH and IRF and SNF PPS proposed rules are released in late April or early May with comment deadlines in early August, and the home health PPS proposed rule will be released in July with comments due in early September. As we do each year, CHA will convene the Center and the forums to review the provisions in the proposed rule and seek member input for our comment letters. We look forward to your participation in this process.

In addition, we expect CMS to finalize its changes to the home health conditions of participation that were proposed in 2015 and we may also see other refinements to policies issued under sub-regulatory guidance. We also anticipate that the Centers for Medicare and Medicaid Innovation will continue to release reports updating Congress on the progress of various payment and system delivery reforms. Their most recent report was released at the end of 2014 and lacked any significant findings of their progress to date in being able to scale any of their innovations at a national level.

Finally, after five years at CMS, Administrator Marilyn Tavenner told staff last week she will leave the agency at the end of February. Andy Slavitt, currently principal deputy administrator, will become acting administrator. With the announcement of departure of Tavenner, CMS will be without a confirmed administrator until such time as the President selects a nominee and the nominee is confirmed by the Senate. With both a republican controlled House and Senate, we do not anticipate a new administrator to be confirmed in the near future. This announcement follows the announcement that Cindy Mann, Director for the Centers for Medicaid and Melanie Bella, Director for the Office of the Dual Eligibles who are also departing this month, leaving a significant void in CMS expertise and leadership.

Absent confirmed leadership, the agency will struggle to implement difficult policy decisions and in the coming months will be very focused on the *Burwell vs. King* case related to whether or not individuals that obtain health care coverage through the federal exchange, rather than a state run exchange like Covered California can continue to receive federal subsidies. The Supreme Court is scheduled to hear the case in March with a verdict expected the last week in June. The outcome of that court decision could set forth a number of legislative and regulatory changes in the months following. While the decision will not have any impact for those covered under the California exchange, CHA is monitoring this decision very closely.
Recovery Audit Program Improvements

As the current Recovery Auditor contracts come to a close and the new contracts are being prepared, CMS has evaluated a number of concerns raised about the program and is now pleased to announce a number of changes to the Recovery Audit Program in response to industry feedback. The CMS is confident that these changes will result in a more effective and efficient program, by enhanced oversight, reduced provider burden, and more program transparency. These changes will be effective with each new contract award beginning with the DME, Home Health and Hospice Recovery Audit contract awarded on December 30, 2014.

<table>
<thead>
<tr>
<th>Provider Concern</th>
<th>Benefit to Provider Community</th>
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<tr>
<td><strong>Reducing Provider Burden</strong></td>
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<tr>
<td>A1. ADR limits are the same for all providers of similar size and are not adjusted based on a provider’s compliance with Medicare rules.</td>
<td>CMS will establish ADR limits based on a provider’s compliance with Medicare rules. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits. The ADR limits will be adjusted as a provider’s denial rate decreases, ensuring the provider that complies with Medicare rules has less Recovery Audit reviews.</td>
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<td>A2. To comply with timely filing rules, hospitals must submit a claim within 1 year from the date of service, but the Recovery Auditors have a 3-year look-back period, which results in acute inpatient hospitals being unable to rebill denials from patient status reviews.</td>
<td>CMS will limit the Recovery Auditor look-back period to 6 months from the date of service for patient status reviews, in cases where the hospital submits the claim within 3 months of the date of service.</td>
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<td>A3. Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in departments within the facility.</td>
<td>CMS established ADR limits will be diversified across all claim types of a facility (e.g., inpatient, outpatient). This ensures that a provider with multiple claim types is not disproportionately impacted by Recovery Audit review in one claim type (e.g. all of a provider’s inpatient rehabilitation claims reviewed or all inpatient).</td>
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<td>A4. Providers who are not familiar with the Recovery Audit Program immediately receive requests for the maximum number of medical records allowed.</td>
<td>CMS established ADR limits will include instructions to incrementally apply the limits to new providers under review. This will ensure that a new provider is able to respond to the request timely and with current staffing levels.</td>
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<td>A5. ADR limits for physicians should not be increased with the new contracts.</td>
<td>At the beginning of the new contracts, CMS will not increase the ADR limits for physicians.</td>
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<td>A6. Providers must wait 60 days before being notified of the outcome of their complex reviews</td>
<td>Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings. This provides more immediate feedback to the provider on the outcome of their reviews.</td>
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<td>A7. Recovery Audits should be conducted by</td>
<td>Recovery Auditors are required to have a</td>
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<td>physicians of the same specialty or subspecialty.</td>
<td>Contractor Medical Director and are encouraged to have a panel of specialists available for consultation. In addition, physicians are afforded the opportunity to discuss the improper payment identification with the Contractor Medical Director, who is a physician.</td>
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<tr>
<td>A8. Upon notification of an appeal by a provider, the Recovery Auditor is required to stop the discussion period.</td>
<td>Recovery Auditors must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal and can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment.</td>
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<td>A9. Providers do not receive confirmation that their discussion request or other written correspondence has been received.</td>
<td>Recovery Auditors must confirm receipt of a provider’s discussion request or other written correspondence within three business days.</td>
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<td>A10. Each Recovery Auditor’s provider portal is formatted differently and some show different information than others.</td>
<td>CMS will work with Recovery Auditors to enhance their provider portals, including more uniformity and consistency in the claim status section, as well as display reason statement identifiers where available.</td>
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<td>A11. Providers receiving Periodic Interim Payments (PIP) may have their entire payment offset due to improper payment adjustments.</td>
<td>The revised ADR limits will help ensure PIP providers are not negatively impacted with improper payment adjustments. However, if a backlog were to exist, CMS would require incremental adjustments to ensure there was not a full recovery of a PIP. This will ensure that PIP providers’ cash flow is not negatively impacted by the Recovery Auditors.</td>
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<td>A12. Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.</td>
<td>Recovery Auditors will not receive a contingency fee until after the second level of appeal is exhausted. Previously, Recovery Auditors were paid immediately upon denial and recoupment of the claim. This delay in payment helps assure providers that the decision made by the Recovery Auditor was correct based on Medicare’s statutes, coverage determinations, regulations and manuals. Note: if claims are overturned on appeal, providers are paid interest calculated from the date of recoupment. For more information please visit Enhancing CMS’ Oversight</td>
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<td>Issue Description</td>
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<tr>
<td>B1.</td>
<td>CMS did not provide enough public information about the Recovery Audit Program.</td>
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<tr>
<td>B2.</td>
<td>Recovery Auditors focused much of their resources on inpatient hospital claims.</td>
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<tr>
<td>B3.</td>
<td>Recovery Auditors are not penalized for high appeal overturn rates.</td>
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<tr>
<td>B4.</td>
<td>Providers are concerned with the accuracy of Recovery Auditor automated reviews and Recovery Auditors are not penalized for low accuracy rates.</td>
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**Increasing Program Transparency**

<table>
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<tr>
<th></th>
<th>Issue Description</th>
<th>Solution Description</th>
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<tbody>
<tr>
<td>C1.</td>
<td>Providers are unsure of who to contact when they have complaints/concerns about the Recovery Audit program.</td>
<td>CMS established a Provider Relations Coordinator to offer more efficient resolutions to affected providers. This position gives providers a name and contact information when issues arise that cannot be solved by having discussions with the Recovery Auditor.</td>
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<td>C2.</td>
<td>Providers need more information on the Recovery Audit Program.</td>
<td>CMS will continue to post Provider Compliance guidelines and information related to the Recovery Audit Program.</td>
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<td><strong>how to prevent improper payments and bill correctly.</strong></td>
<td><strong>Tips to the CMS website. These compliance tips, in addition to education and MLN Matters articles give information to help providers prevent errors before they occur.</strong></td>
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<td><strong>C3.</strong> Providers are unclear about the information in the Recovery Auditor new issue website postings.</td>
<td>CMS will require the Recovery Auditors to provide consistent and more detailed review information concerning new issues to their websites. This will allow providers to easily navigate all of the issues that may be under Recovery Audit review.</td>
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<td><strong>C4. CMS does not have a valid method for providers to rate each Recovery Auditor’s performance.</strong></td>
<td>CMS will consider developing a Provider Satisfaction Survey. This survey would give providers an outlet to give feedback to CMS on the Recovery Auditors performance.</td>
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January 14, 2015

TO: Center for Post-Acute Care Advisory Board

FROM: Pamela Roberts, Ph.D, Manager, Rehabilitation and Neuropsychology, Cedars- Sinai Medical Center, Department of PM&R.
Alyssa Keefe, Vice President, Federal Regulatory Affairs

SUBJECT: Quality Reporting

SUMMARY

Quality reporting programs, pay for performance and other models of value-based purchasing, have become an integral part of Medicare prospective payment systems and have significant implications for hospitals and post-acute care providers. CHA and its members are actively involved in advocacy and communication on quality reporting programs and their implications for providers.

ACTION REQUESTED

- To provide an update on the NQF readmissions measures
- To provide an update on the Measures Application Partnership recommendations for quality measures

DISCUSSION

**NQF Readmissions Measure**

Hospitals and health care providers at levels of the continuum of care are required, or will be required, to report data regarding hospital re-admissions. Providers will be subject to penalties for failing to report or for excessive readmission rates. The NQF board executive committee recently approved recommended measures with specific conditions, including a requirement that the admissions/readmission standing committee determine which measures must enter the trial period for consideration of socio-demographic status (SDS), and a requirement for a one-year look-back assessment of unintended consequences. The measures were endorsed with these conditions to ensure that concerns expressed throughout the consensus by CHA and others were addressed.

**Measures Application Partnership Quality Measures**

The Measures Applications Partnership (MAP) has issued its preliminary recommendations for quality measures under consideration by the U.S. Department of Health and Human Services (HHS) for future inclusion in federal quality reporting programs. CHA attended the MAP’s
meetings in December and held member calls to solicit input on the measures under consideration, which include several applicable to post-acute care settings. Based on that feedback, CHA submitted comments on behalf of members.

Attachments
MAP CHA Comment Letter
NQF Update
January 13, 2015

George J. Isham, MD, MS  Elizabeth A. McGlynn, PhD, MPP  
Co-Chair, Coordinating Committee  Co-Chair, Coordinating Committee  
Measures Applications Partnership  Measures Applications Partnership  
National Quality Forum  National Quality Forum  
1030 15th Street, NW, Suite 800  1030 15th Street, NW, Suite 800  
Washington, DC 20005  Washington, DC 20005

Dear Dr. Isham and Dr. McGlynn,

On behalf of the more than 400 member hospitals and health systems, including post-acute care providers, the California Hospital Association (CHA) appreciates the opportunity to comment on the draft 2015 recommendations of the Measures Application Partnership (MAP).

CHA appreciates the time and effort that volunteers, representing consumers, purchasers and providers have dedicated to careful review of quality measures that are under consideration by the Centers for Medicare & Medicaid Services (CMS) for inclusion in federal public reporting and performance based programs. Overall, CHA is generally supportive of many of the recommendations of this report and acknowledge the tremendous staff work of the NQF in streamlining this process over the past year. We offer the following comments and recommendations for consideration below.

The Measures Under Consideration (MUC) List
CHA is grateful for the opportunity to review the Measures Under Consideration (MUC) list prior to workgroup discussions of the MAP. However, the timing of the release of the MUC list, its format and the volume of measures for review make it very difficult to provide meaningful comment. CHA is grateful that CMS and NQF staff worked to provide the MUC list an Excel format so that we could easily create worksheets for review by our member hospitals. CHA hosted three separate 90 minute member calls prior to the workgroup discussions with our acute care hospitals, our post-acute care providers including inpatient rehab facilities, long-term care hospitals, skilled nursing, home health and hospice and finally with our inpatient psychiatric facility hospitals and units. In reviewing the MUC list, we offer the following recommendations for consideration.

- Provide the MUC list in useable format, including links to the most recent revisions to the measure specifications.
  CHA appreciates the tremendous resources HHS devotes to creating such a list, however, we believe it lacks some pieces of critical information that would be helpful in getting meaningful input from the MAP in this process. First, we would be appreciative if CMS would release an Excel version of the PDF at the same time it releases the PDF of the MUC list. Both should be posted to the CMS and NQF website for easy sorting. Second,
we ask CMS to consider additional information be included. For example, the vast majority of measures currently under consideration by CMS have not been endorsed by the NQF, rather they are in development and often under contract with CMS. We ask that CMS consider hyperlinking to the specific measure specification documents often located on the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html or the NQF measure information sheets. If these documents are not publicly available, the public does not have the opportunity to fully review the details of the measure and CHA would consider these measures in development, and not subject to a formal recommendation of the MAP. Further, because information changes, having links to the most updated versions of the measure specifications that CMS is considering would be most helpful. Third, when measures are removed from consideration, CMS and NQF should immediately post those measures for the public. Understanding why measures come on and off the list would also be important in understanding CMS’ priorities for measure adoption.

- **Specifying the Measure Rationale for the Appropriate Setting**
  In reviewing the post-acute care (PAC) measures, a number of measures are developed for one PAC setting, but under consideration for another. It would improve our understanding of CMS thinking of why a measure is under consideration for a specific setting if a rationale was provided for that setting. For example, often the rationale is prevalence of a condition in a setting – but often there is no data to support the prevalence in the setting in which the measure is intended. A rationale specific to the setting, would be most helpful to the MAP in understanding its relative importance as compared to other measures also under consideration. This information is critical in prioritizing the selection of measures and in the measurement gap prioritization process. This could be accomplished by including hyperlinks in the MUC list to the more specific measure specifications that are likely publicly available on the CMS or NQF website as previously.

**Refining the Consent Calendar and Algorithm for Draft Recommendations for Workgroup Consideration**

The use of a consent calendar and an algorithm for arriving at a draft recommendation for consideration by each of the workgroups is an important improvement to this process however it was not without its challenges and is worthy of further refinement. Because the vast majority of measures currently under consideration by CMS are also measures that CMS has developed, the current status of the measure, its testing and where it was in the process, was not necessarily transparent to the public. There were a number of instances where CMS stated that “measure testing has been completed by the contractor” but no measure testing was available for review by the public. This was of greatest concern for measures that – despite having gone through CMS’ public comment process, in our view still lacked critical information to be considered for a consent calendar other than the encourage or discourage continued development.

It is our hope that CMS will continue to provide additional information on measures under development prior to MAP workgroup deliberations. If not in the room for a CMS contractor presentation, it’s difficult to provide informed comments. Further, having that information provided the same day the group is asked to make a formal recommendation, does not allow
enough time for workgroup members to appropriately review and yet the information prior to making a formal support, conditional support or do not support recommendation.

**Further Work Needed to Prioritize Measurement Adoption and Measurement Gaps**

Each of the sections of the draft report details areas for measure development, many of which propose to align with other programs. For example, the MAP is explicit in their call for overlap between measures selected for the inpatient quality reporting (IQR) program and hospital value based purchasing (VBP). We agree because, by law a measure must first be adopted in the IQR program and publicly reported for one year before being included in VBP and therefore we should see overlap in these measurement gaps. However, CHA is concerned that the MAP has not further refined and prioritized the measurement gaps to provide clear direction to CMS regarding measurement priorities. CHA supports the comments of the American Hospital Association submitted on December 22 that call for a more focused approach to measure selection and development. California hospitals bear one of the greatest burdens in reporting. CHA works tirelessly to bring further alignment to the state and federal quality reporting programs while at the same time working with our commercial payers as well as local and regional quality collaboratives on measure selection and prioritization. The section of the report that addresses Progress in Aligning Measures gives an overview of what we know to be true – that there is little alignment, but makes no specific recommendations on how CMS, NQF or the MAP can begin to tackle this critically important work. We believe strongly that this should be a concerted and focused effort over the next year and believe the AHA has provided an appropriate starting place for this work.

CHA appreciates the opportunity to comment on the draft recommendations. 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
National Quality Forum Update

National Quality Forum (NQF) Mission:
To improve the quality of American healthcare by:
- Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them
- Endorsing national consensus standard for measuring and publicly reporting on performance
- Promoting the attainment of national goals through education and outreach programs

NQF Focus on Harmonization:

NQF Evaluation Criteria for Measures:
- Importance to measure and report
  - What is the level of evidence for the measures?
  - Is there an opportunity for improvement?
  - Relation to a priority area or high impact area of care
- Scientific acceptability of the measurement properties
  - What is the reliability and validity of the measure?
- Usability
  - Are the measure results meaningful and understandable to intended audiences and use for both public reporting and informing quality improvement
- Feasibility
  - Can the measure be implemented without undue burden, capture with electronic data/EHRs?
All Cause Admission and Readmission Steering Committee

- The NQF Board Executive Committee unanimously to endorse [17] admission and readmission measures only with the following conditions:
  1. Admissions/Readmissions Standing Committee will determine which measures must enter the NQF trial period for consideration of socio-demographic status (SDS) adjustment
  2. One-year look-back assessment of unintended consequences.
     - Admissions/Readmissions Standing Committee and CMS to determine a plan for assessing potential unintended consequences
     - The evaluation of unintended consequences will be initiated within approximately one year and possible changes to the measures based on these data will be discussed at that time
- Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors TECHNICAL REPORT from August 15, 2014—available on NQF website [www.qualityforum.org]
- Possible SDS risk factors for examination may include:
  - Income
  - level of education
  - homelessness status,
  - English language proficiency
  - health insurance status
  - occupation
  - employment status
  - literacy
  - health literacy, or neighborhood-level data that can be used as a proxy for individual data such as median neighborhood income, education, or local funding availability for safety net providers

17 Measures

- Measure 2375: PointRight® OnPoint-30 SNF Rehospitalizations
- Measure 2510: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- Measure 2380: Rehospitalization During the First 30 Days of Home Health
- Measure 2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health
- Measure 2512: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)
- Measure 2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)
- Measure 2393: Pediatric All-Condition Readmission Measure
- Measure 2414: Pediatric Lower Respiratory Infection Readmission Measure
- Measure 2496: Standardized Readmission Ratio (SRR) for dialysis facilities
- Measure 2503: Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
- Measure 2504: 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
- Measure 0505: Hospital 30-day all-cause risk-standardized readmission rate
- (RSRR) following acute myocardial infarction (AMI) hospitalization
- Measure 0695: Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)
- Measure 2513: Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures (ZIP)
- Measure 2514: Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate
- Measure 2515: Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery
- Measure 2539: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Membership Applications Partnership (MAP)

Purpose: Affordable Care Act (ACA) requires Health and Human Services to contract with consensus-based entity (NQF) to convene multi-stakeholder groups to provide input on the selection of quality measures for public reporting, payment and other programs
- Review and provide input on measures for Post-Acute Care/Long Term Care on measures under consideration for federal programs applicable to clinician settings
- Identify high-priority measure gaps for each program measure set
- Finalize input to the MAP Coordinating Committee on measures for use in federal programs

Map Structure
PAC/LTC High-Leverage Opportunities and Core Measure Concepts

<table>
<thead>
<tr>
<th>Highest-Leverage Areas for Performance Measurement</th>
<th>Core Measure Concepts</th>
</tr>
</thead>
</table>
| Function                                         | • Functional and cognitive status assessment  
|                                                  | • Mental health                        |
| Goal Attainment                                  | • Establishment of patient/family/caregiver goals  
|                                                  | • Advanced care planning and treatment   |
| Patient Engagement                               | • Experience of care                   |
|                                                  | • Shared decision-making               |
| Care Coordination                                | • Transition planning                  |
| Safety                                           | • Falls                                |
|                                                  | • Pressure ulcers                      |
|                                                  | • Adverse drug events                  |
| Cost/Access                                      | • Inappropriate medicine use           |
|                                                  | • Infection rates                      |
|                                                  | • Avoidable admissions                 |

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM
Measures Reviewed at December 2014 Meeting

- For each area: Provide recommendations on measures under consideration and identify high-priority measure gaps for the program

Pre-Rulemaking Input on Measures under Consideration for Inpatient Rehabilitation Facilities Quality Reporting Program

- **Venous Thromboembolism Prophylaxis (MUC ID: E0371)**
  Description: This measure assesses the number of patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE (VTE-2: ICU VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: Hospital Acquired Potentially-Preventable VTE) that are used in The Joint Commission’s accreditation process.

- **IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (MUC ID: S2633)**
  Description: This measure estimates the average risk-adjusted mean change in self-care function between admission and discharge for patients discharged from IRFs.
• **IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (MUC ID: S2634)**
  Description: This quality measure estimates the average risk-adjusted mean change in mobility function between admission and discharge for patients discharged from an IRF.

• **IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (MUC ID: S2635)**
  Description: This quality measure calculates the percent of patients who meet or exceed an expected discharge self-care score in IRFs.

• **IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (MUC ID: S2636)**
  Description: This measure calculates the percent of patients who meet or exceed an expected discharge mobility score.

**Pre-Rulemaking Input on Measures under Consideration for Skilled Nursing Facilities Value-Based Purchasing Program**

• **Skilled Nursing Facility All-Cause 30 Day Post Discharge Readmission Measure (MUC ID: S2510)**
  Description: This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) (Medicare fee-for-service [FFS] beneficiaries) within 30 days of discharge from their prior proximal hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, or a psychiatric hospital. The measure is based on data for 12 months of SNF admissions. A risk-adjusted readmission rate for each facility is calculated as follows:

  Step 1: Calculate the standardized risk ratio of the predicted number of readmissions at the facility divided by the expected number of readmissions for the same patients if treated at the average facility. The magnitude of the risk-standardized ratio is the indicator of a facility’s effects on readmission rates. Step 2: The standardized risk ratio is then multiplied by the mean rate of readmission in the population (i.e., all Medicare FFS patients included in the measure) to generate the facility-level standardized readmission rate. For this measure, readmissions that are usually for planned procedures are excluded. Please refer to the Appendix, Tables 1 - 5 for a list of planned procedures. The measure specifications are designed to harmonize with CMS’s hospital-wide readmission (HWR) measure to the greatest extent possible. The HWR (NQF #1789) estimates the hospital-level, risk-standardize rate of unplanned, all-cause readmissions within 30 days of a hospital discharge and uses the same 30-day risk window as the SNFRM.

**Pre-Rulemaking Input on Measures under Consideration for Medicare Shared Savings Program**

• **Acute Care Hospitalization (Claims-Based) (MUC ID: E0171)**
  Description: Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.

• **Documentation of Current Medications in the Medical Record (MUC ID: E0419)**
Description: Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.

- **Antipsychotic Use in Persons with Dementia (MUC ID: E2111)**
  Description: The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.

- **Skilled Nursing Facility All-Cause 30 Day Post Discharge Readmission Measure (MUC ID: S2510)**
  Description: This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) (Medicare fee-for-service [FFS] beneficiaries) within 30 days of discharge from their prior proximal hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, or a psychiatric hospital. The measure is based on data for 12 months of SNF admissions. A risk-adjusted readmission rate for each facility is calculated as follows: Step 1: Calculate the standardized risk ratio of the predicted number of readmissions at the facility divided by the expected number of readmissions for the same patients if treated at the average facility. The magnitude of the risk-standardized ratio is the indicator of a facility’s effects on readmission rates. Step 2: The standardized risk ratio is then multiplied by the mean rate of readmission in the population (i.e., all Medicare FFS patients included in the measure) to generate the facility-level standardized readmission rate. For this measure, readmissions that are usually for planned procedures are excluded. Please refer to the Appendix, Tables 1 - 5 for a list of planned procedures. The measure specifications are designed to harmonize with CMS’s hospital-wide readmission (HWR) measure to the greatest extent possible. The HWR (NQF #1789) estimates the hospital-level, risk-standardize rate of unplanned, all-cause readmissions within 30 days of a hospital discharge and uses the same 30-day risk window as the SNFRM.

**Pre-Rulemaking Input on Measures under Consideration for Long-Term Care Hospital Quality Reporting Program**

- **Venous Thromboembolism Prophylaxis (MUC ID: E0371)**
  Description: This measure assesses the number of patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE (VTE-2: ICU VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: Hospital Acquired Potentially-Preventable VTE) that are used in The Joint Commission’s accreditation process.
• **Compliance with Ventilator Process Elements during LTCH stay (MUC ID: X3705)**
  Description: This measure "Compliance with Ventilator Process Elements during LTCH stay" is a paired quality measure (QM#1 and QM#2); it assesses facility-level compliance with Ventilator Process Elements for eligible patients in the LTCH setting. Quality Measure #1: Compliance with Tracheostomy Collar Trial (TCT) or Spontaneous Breathing Trial (SBT) by the end of the first calendar day following admission to the LTCH. Quality Measure #2: Compliance with TCT or SBT during LTCH stay - day 2 through discharge date/ date when patient is fully weaned. Definitions: i. Invasive mechanical ventilation: The use of a device to assist or control pulmonary ventilation, either intermittently or continuously through a tracheostomy or by endotracheal intubation. ii. Tracheostomy Collar Trial: Trial of unassisted breathing via a tracheostomy collar (mask) with aerosol (mist), administered to patients with tracheostomy tubes. iii. Spontaneous Breathing Trial: Trial of unassisted breathing for at least X time period and full ventilator support at night, administered to patients with endotracheal tubes.

• **Ventilator Weaning (Liberation) Rate (MUC ID: X3706)**
  Description: This measure assesses facility-level patient weaning (liberation) rate for patients in the LTCH setting. This measure reports the percentage of patients who are discharged from a Long-Term Care Hospital (LTCH) and reported as successfully (fully) weaned at discharge. The measure will analyze and report the fully weaned and not weaned separately for patients discharged alive. The measure will also analyze and report on weaning status of patients who die. Definitions: i. Invasive mechanical ventilation: The use of a device to assist or control pulmonary ventilation, either intermittently or continuously through a tracheostomy or by endotracheal intubation. ii. Weaning covers the entire process of liberating the patient from invasive mechanical ventilation support. iii. Fully weaned: Patients who are discharged alive from a LTCH and require no invasive mechanical ventilation support for 72 consecutive hours or more during 3 consecutive days immediately prior to discharge. iv. Not weaned (invasive mechanical ventilation dependent): Patients who require continuous invasive mechanical ventilation support for more than 12 consecutive hours per day during each of the 3 consecutive calendar days immediately prior to discharge.

**Pre-Rulemaking Input on Measures under Consideration for Home Health Quality Reporting Program**

• **Percent of Patients with Pressure Ulcers That Are New or Worsened (MUC ID: X3704)**
  Description: Percentage of home health episodes of care in which the patient is discharged from home health with one or more pressure ulcer(s) that are Stage 2 - 4 or unstageable due to slough or eschar and are new or worsened since the start or resumption of care. The measure is based on data obtained from the Outcome Assessment and Information Set (OASIS-C1) Data Item Set.
Pre-Rulemaking Input on Measure under Consideration for End-Stage Renal Disease Quality Incentive Program

- **Cultural Competency Implementation Measure (MUC ID: E1919)**
  Description: The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for quality improvement, provide information that can help health care organizations establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting.

- **Cultural Competency Reporting Measure (MUC ID: X3716)**
  Description: This reporting measure is designed to collect data needed to score NQF #1919 in the ESRD QIP.

- **Documentation of Current Medications in the Medical Record (MUC ID: E0419)**
  Description: Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.

- **Medications Documentation Reporting (MUC ID: X3721)**
  Description: This reporting measure is designed to collect data needed to score NQF #0419 in the ESRD QIP.

- **Delivered Dose of Dialysis Above Minimum - Composite Score (MUC ID: X2051)**
  Description: Percentage of all patient months whose delivered dose of dialysis (either hemo or peritoneal) met the specified threshold. This measure is a composite of NQF #0318 and NQF #0249.

- **Delivered Dose of Hemodialysis Above Minimum (MUC ID: X3717)**
  Description: Percentage of all patient months whose average delivered dose of hemodialysis (calculated from the last measurements of the month using the UKM or Daugirdas II formula) was a spKt/V >= 1.2.

- **Delivered Dose in Peritoneal Dialysis Above Minimum (MUC ID: X3718)**
  Description: Percentage of all patient months whose delivered peritoneal dialysis dose was a weekly Kt/V urea of at least 1.7 within past four months (Adult >= 18) or 1.8 within past 6 months (pediatric).
January 28, 2015

TO: Center for Post-Acute Care Advisory Board
FROM: Patricia Blaisdell, Vice President, Post-Acute Care Services
       Barbara Glaser, Senior Legislative Advocate
SUBJECT: State Affairs Update

SUMMARY

Regulatory and legislative activities at the state level have significant implications for CHA member post-acute care providers.

ACTION REQUESTED

- To provide an overview of the upcoming state legislative session, including discussion of CHA’s legislative priorities and anticipated bill proposals.
- To provide an update on the state budget.
- To provide an update on the implementation of Cal MediConnect and the Coordinated Care Initiative (CCI)

DISCUSSION

Current state legislative and regulatory issues will be reviewed and discussed, with an emphasis on implications for hospitals and for hospital and health system post-acute care providers, and the identification of recommended actions.

State Legislation
The legislature reconvened on January 5, 2015. Bill requests must be submitted by January 30 and introduced by February 27. CHA has identified legislative priorities for the current legislative session, and will monitor proposed legislation.

State Budget
The Governor’s proposed budget was issued on January 10.

Cal MediConnect/ Coordinated Care Initiative
Implementation of Cal MediConnect and the Coordinated Care Initiative (CCI) is ongoing. Enrollment for beneficiaries in San Mateo, San Diego, San Bernardino, Riverside and LA Counties began earlier this year. Santa Clara County is scheduled to begin enrollment in January 2015, while implementation is currently on hold, with possible implementation later this year.
CHA members have reported several issues with program implementation, including enrollment of ineligible/exempted beneficiaries, inconsistent communication with plans regarding coverage and authorization procedures, and physician participation and consequences for access and continuity of care.

Association staff members at both state and regional levels are actively involved in communication with DHCS personnel, plan personnel, hospitals and other key stakeholders. Current discussions focus on facilitating communication between plans and providers, as well as addressing issues associated with beneficiary enrollment and care authorizations.

Attachments
CMC Enrollment Dashboard January 2015
CMC Enrollment Dashboard November 2014 & January 2015
2014 HR Legislative Summary
Cal MediConnect Monthly Enrollment Dashboard
As of January 1, 2015

Total Active Enrollments Effective January 1, 2015
by County

Total Active Enrollments 122,908

Los Angeles, 56,240
San Diego, 19,683
San Bernardino, 14,398
Riverside, 14,536
San Mateo, 10,226
Santa Clara, 7,825

Projected Enrollments - Two Month Look Ahead

<table>
<thead>
<tr>
<th>County</th>
<th>Active Enrollments as of 1/1/15</th>
<th>February Pending Enrollments</th>
<th>March Pending Enrollments</th>
<th>Total Projected Enrollments for March Month of Eligibility*</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Mateo</td>
<td>10,226</td>
<td>1</td>
<td>0</td>
<td>10,227</td>
</tr>
<tr>
<td>Riverside</td>
<td>14,536</td>
<td>1,086</td>
<td>1,501</td>
<td>17,123</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>14,998</td>
<td>1,073</td>
<td>1,886</td>
<td>16,857</td>
</tr>
<tr>
<td>San Diego</td>
<td>19,683</td>
<td>1,776</td>
<td>2,427</td>
<td>23,886</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>56,240</td>
<td>6,999</td>
<td>12,276</td>
<td>75,515</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>7,825</td>
<td>1,307</td>
<td>1,875</td>
<td>11,007</td>
</tr>
<tr>
<td>Total</td>
<td>122,908</td>
<td>12,242</td>
<td>19,465</td>
<td>154,615</td>
</tr>
</tbody>
</table>

* Projected enrollments are based on passive enrollment transactions submitted 60-days prior to the enrollment effective month. Voluntary (Opt-in) enrollment projections are not included in these statistics.

Total Active Enrollments Effective January 1, 2015
By Plan

Projected Enrollment Estimates for March 2015 Month of Eligibility
by Plan

Data Sources: MIEDS January MOE 2015, pulled on 1/7/15
# Cal MediConnect Monthly Enrollment Dashboard

As of January 1, 2015

## DHCS Health Care Options Mailing Schedule

<table>
<thead>
<tr>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase →</td>
<td>1</td>
</tr>
<tr>
<td>For Coverage Effective Date →</td>
<td>May 1&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>90-day notice volume →</td>
<td>21,805</td>
</tr>
<tr>
<td>60-day notice volume →</td>
<td>21,805</td>
</tr>
<tr>
<td>60-day+choice packet volume →</td>
<td>18,122</td>
</tr>
<tr>
<td>30-day notice volume →</td>
<td>15,360</td>
</tr>
</tbody>
</table>


2. Mailings for May 1, 2014 coverage start date include April and May birth months.

## HCO Call Center Statistics December 2014

<table>
<thead>
<tr>
<th>For Week Ending</th>
<th>Total Calls Received&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Total Calls Answered</th>
<th>Total Calls Abandoned</th>
<th>Average Abandon Rate</th>
<th>Average Talk Time (Minutes)</th>
<th>Average Wait Time (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/05/14</td>
<td>31,609</td>
<td>22,447</td>
<td>2,172</td>
<td>6.78%</td>
<td>10.15</td>
<td>1.88</td>
</tr>
<tr>
<td>12/12/14</td>
<td>22,071</td>
<td>19,189</td>
<td>666</td>
<td>2.51%</td>
<td>9.87</td>
<td>0.78</td>
</tr>
<tr>
<td>12/19/14</td>
<td>14,581</td>
<td>13,773</td>
<td>206</td>
<td>1.25%</td>
<td>10.12</td>
<td>0.49</td>
</tr>
<tr>
<td>12/26/14</td>
<td>6,789</td>
<td>6,496</td>
<td>66</td>
<td>0.89%</td>
<td>9.89</td>
<td>0.15</td>
</tr>
<tr>
<td>12/31/14</td>
<td>6,966</td>
<td>6,632</td>
<td>59</td>
<td>0.90%</td>
<td>9.82</td>
<td>0.39</td>
</tr>
<tr>
<td>Totals</td>
<td>82,016</td>
<td>68,537</td>
<td>3,169</td>
<td>3.86%</td>
<td>9.99</td>
<td>0.83</td>
</tr>
</tbody>
</table>

1. Total calls received are hits to the call center system. Members may receive assistance in an automated phone tree, therefore are not accounted for in the call answered or abandoned counts.

## Opt-out Requests by Month/County

<table>
<thead>
<tr>
<th>County</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Totals&lt;sup&gt;3&lt;/sup&gt;</th>
<th>% of Passive&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Mateo</td>
<td>29</td>
<td>97</td>
<td>10</td>
<td>1,568</td>
<td>13.43%</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>1,411</td>
<td>1,395</td>
<td>1,428</td>
<td>10,823</td>
<td>32.92%</td>
</tr>
<tr>
<td>San Diego</td>
<td>2,805</td>
<td>3,236</td>
<td>3,931</td>
<td>22,056</td>
<td>30.39%</td>
</tr>
<tr>
<td>Riverside</td>
<td>1,437</td>
<td>1,440</td>
<td>1,385</td>
<td>10,488</td>
<td>32.74%</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>15,343</td>
<td>16,279</td>
<td>18,048</td>
<td>109,282</td>
<td>50.24%</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>717</td>
<td>2,306</td>
<td>2,667</td>
<td>5,690</td>
<td>31.53%</td>
</tr>
<tr>
<td>Total</td>
<td>21,742</td>
<td>24,753</td>
<td>27,469</td>
<td>159,907</td>
<td>43.44%</td>
</tr>
</tbody>
</table>

1. Table includes the most recent three months of opt out counts (which includes voluntary disenrollments).

2. Totals are cumulative opt-out requests from the start of the CalMedconnect program.

3. The Opt-out % is calculated based on the total number of opt-out and voluntary disenrollment requests divided by the total number of beneficiaries who received a 90-day notice through Phase 11.

## Opt-out Trend (Most Recent Three Months)

```
          October  November  December
Opt-out:  107,085  132,418  159,907
Total:   21,742  24,753   27,469
```


2. Mailings for May 1, 2014 coverage start date include April and May birth months.

## Data Sources:

- Beneficiary notice schedule: from Maximus and HPSM notice timeline reports
- Call Center Statistics: HCO Weekly CCI Call Center Report dated 12/31/14

**Note:**

1. The San Mateo mailing schedule for the 4/1/14 passive enrollment phase is reported in earlier versions of the Dashboard from September 2014 and prior.
### November 2014 Cal MediConnect Enrollment, Opt Out and Disenrollment

<table>
<thead>
<tr>
<th>County</th>
<th>Overall Enrolled</th>
<th>Overall Opt-Out</th>
<th>Overall Disenrolled</th>
<th>IHSS Enrolled</th>
<th>IHSS Opt-Out</th>
<th>IHSS Disenrolled</th>
<th>Non-IHSS Enrolled</th>
<th>Non-IHSS Opt-Out</th>
<th>Non-IHSS Disenrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>25%</td>
<td>61%</td>
<td>15%</td>
<td>13%</td>
<td>73%</td>
<td>15%</td>
<td>33%</td>
<td>52%</td>
<td>15%</td>
</tr>
<tr>
<td>Riverside</td>
<td>43%</td>
<td>43%</td>
<td>13%</td>
<td>33%</td>
<td>50%</td>
<td>17%</td>
<td>47%</td>
<td>41%</td>
<td>12%</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>39%</td>
<td>47%</td>
<td>14%</td>
<td>31%</td>
<td>53%</td>
<td>16%</td>
<td>42%</td>
<td>45%</td>
<td>13%</td>
</tr>
<tr>
<td>San Diego</td>
<td>37%</td>
<td>45%</td>
<td>18%</td>
<td>23%</td>
<td>55%</td>
<td>22%</td>
<td>41%</td>
<td>42%</td>
<td>17%</td>
</tr>
<tr>
<td>San Mateo</td>
<td>66%</td>
<td>34%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31%</strong></td>
<td><strong>54%</strong></td>
<td><strong>15%</strong></td>
<td><strong>17%</strong></td>
<td><strong>68%</strong></td>
<td><strong>16%</strong></td>
<td><strong>37%</strong></td>
<td><strong>48%</strong></td>
<td><strong>15%</strong></td>
</tr>
<tr>
<td><strong>Total w/o LA</strong></td>
<td><strong>41%</strong></td>
<td><strong>44%</strong></td>
<td><strong>14%</strong></td>
<td><strong>28%</strong></td>
<td><strong>53%</strong></td>
<td><strong>19%</strong></td>
<td><strong>43%</strong></td>
<td><strong>43%</strong></td>
<td><strong>15%</strong></td>
</tr>
</tbody>
</table>

Notes:
1: San Mateo information is derived from the CMC Dashboard Data, since Health Plan of San Mateo is responsible for its own enrollment, we do not currently have the data available broken out by population, therefore the total rows for IHSS/Non-IHSS do not include San Mateo.
2: Santa Clara did not begin enrollment until January 2015
3: Disenrolled includes those involuntarily disenrolled, such as those who lose Medi-Cal benefits.

### January 2015 Cal MediConnect Enrollment, Opt Out and Disenrollment

<table>
<thead>
<tr>
<th>County</th>
<th>Overall Enrolled</th>
<th>Overall Opt-Out</th>
<th>Overall Disenrolled</th>
<th>IHSS Enrolled</th>
<th>IHSS Opt-Out</th>
<th>IHSS Disenrolled</th>
<th>Non-IHSS Enrolled</th>
<th>Non-IHSS Opt-Out</th>
<th>Non-IHSS Disenrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>32%</td>
<td>55%</td>
<td>13%</td>
<td>20%</td>
<td>66%</td>
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January 12, 2015

TO: CHA Member Human Resources Executives

FROM: Gail Blanchard-Saiger, Vice President, Labor & Employment

SUBJECT: 2014 Legislative Summary

Below is a summary of new workplace laws that were passed and signed in 2014 as well as recommended action steps. Because of the various legal requirements and complexities, hospitals are encouraged to consult with labor and employment counsel on implementation.

Except as noted, these laws are effective January 1, 2015. Actual statutory language is available at www.leginfo.ca.gov.

Health Care Specific

Healthcare Workplace Violence Prevention Plans (SB 1299; Labor Code § 6401.8)

Summary: Requires Cal/OSHA to develop regulations by July 1, 2016, to require hospitals to develop a workplace violence prevention plan; annually assess and improve upon factors that relate to workplace violence; train all direct patient care workers on specified information; refrain from disallowing an employee from seeking assistance and intervention from local emergency services or law enforcement; and maintain and provide specified information to Cal/OSHA.

Recommended Action Steps: It is recommended that hospitals evaluate their current workplace violence prevention plans, including plans applicable to all off-site locations, and compare their current status to SB 1299 requirements. Although those requirements will not go into effect until July 1, 2016, hospitals should begin addressing any gaps. Further, hospitals should monitor the Cal/OSHA regulatory process so that they can be prepared to address any additional requirements included in the final regulations.

Time Off for Emergency Duty (AB 2536; Labor Code § 230.3)

Summary: Adds to the list of employees eligible for protected time off for emergency duty, to include volunteers of a disaster medical response entity sponsored or requested by the state. Also requires health care employees to notify their employers if they are designated as emergency rescue personnel, and to
notify the employer at the time the employee learns that he/she will be deployed for emergency duty.

**Recommended Action Steps:** Update corporate leave policies to include the additional personnel and notice requirements. Consider whether to notify current employees of their obligation to notify Incorporate a question into your new hire process to elicit information as to whether the individual qualifies as “emergency rescue personnel.”

**Public Hospitals**

*Public Employers: Contracting Services (SB 556; Civil Code § 3273)*

Summary: Prohibits public employers from requiring contractors providing emergency medical services to wear a badge or other item with the public employer’s logo. Applies to contracts entered into after January 1, 2015.

**Recommended Action Steps:** While the bill was not intended to cover public hospital emergency departments, it could be interpreted in that manner. CHA is seeking clarification on this issue. Hospitals should monitor developments and determine whether changes are warranted.

**General Employment Laws**

*Mandatory Paid Sick Leave (AB 1522; Labor Code § 245, et seq.)*

Summary: Effective July 1, 2015, requires employers to provide paid sick leave to any employee who works in California for 30 days within their first year of employment. Paid sick leave is accrued at the rate of one hour for every 30 hours worked, regardless of whether an employee has waived benefits or is otherwise currently considered “non-benefitted.” There are permissible caps on accrual and usage. It is not a vested benefit so it need not be paid on termination of employment. While there is a provision that permits an employer to meet the requirements through an existing paid leave plan, the existing plan must meet all of the technical requirements of the paid sick leave law. There is a carve-out for employees covered by a collective bargaining agreement, a non-retaliation provision, detailed record-keeping and notice requirements, and penalties for noncompliance.

**Recommended Action Steps:** This is a complicated law that will impact hospitals in a variety of ways depending on their specific circumstances. It is recommended that hospitals work with employment counsel to fashion a compliant approach.
Client/Contracting Joint Liability (AB 1897; Labor Code § 2810.3)

Summary: Requires hospitals and other employers that utilize third-party contractors to insure the wage and hour obligations, workers’ compensation coverage, and occupational health and safety duties of the contracting employer’s employees.

Recommended Action Steps: Hospitals should review all third-party staffing contracts (temporary, long-term, etc.) to evaluate indemnification provisions as well as develop a process for ensuring the third-party contractor is complying with wage and hour laws, as well as providing workers compensation coverage, on an ongoing basis.

Fair Employment & Housing Act Expansion (AB 1443; Government Code § 12940)

Summary: Effective January 1, 2015, the California Fair Employment and Housing Act was expanded to prohibit discrimination and harassment of paid and unpaid interns, and to prohibit harassment of volunteers.

Recommended Action Steps: Hospitals should revise their non-discrimination and harassment policies to ensure they encompass interns, and revise harassment policies to ensure they cover volunteers. In addition, staff supervising interns and volunteers should be specifically trained on these new requirements.

Fair Employment & Housing Act Harassment Training (AB 2053; Government Code § 12950.1)

Summary: Employers’ obligation to provide sexual harassment training is expanded to include “abusive conduct.” Abusive conduct is defined as the conduct of an employer or employee in the workplace, with malice, that a reasonable person would find hostile, offensive and unrelated to an employer’s legitimate business interests. Abusive conduct may include repeated infliction of verbal abuse, such as the use of derogatory remarks, insults and epithets; verbal or physical conduct that a reasonable person would find threatening, intimidating, or humiliating; or the gratuitous sabotage or undermining of a person’s work performance.

Recommended Action Steps: Although this law does not change the legal standard for harassment, it requires hospitals to revise anti-harassment training to incorporate this new requirement.
Waiver of Rights/Arbitration (SB 2617; Civil Code § 51.7, 52, 52.1)

Summary: Precludes an employer or business from requiring arbitration of claims under the Ralph Civil Rights Act and the Tom Bane Civil Rights Act. Arguably this could extend to employment and independent contractor relationships.

Recommended Action Steps: This statute is likely invalid under the Federal Arbitration Act. Hospitals should review any employment-related arbitration agreements and determine whether changes are warranted.

Foreign Labor Contractors (SB 477; Business and Professions Code § 9998.1, 9998.1.5, 9998.2, 9998.2.5, 9998.6, 9998.8, 9998.10, 9998.11)

Summary: Requires foreign labor contractors to meet registration, licensing and bonding requirements by July 1, 2016. The law also imposes numerous notice requirements on foreign labor contractors. Employers are prohibited from using non-registered foreign labor contractors to supply employees in California. There are penalties for noncompliance and joint liability for employers who use non-registered foreign labor contractors.

Recommended Action Steps: Hospitals should determine whether foreign labor contractors used are preparing for the registration, licensing and bonding requirements. Hospitals should also review contracts with foreign labor contractors to evaluate indemnification provisions as well as develop a process for ensuring foreign labor contractors are complying with the law on an ongoing basis.

Unfair Immigration Practices (AB 2751; Labor Code § 98.6, 1019, 1024.6)

Summary: Expands the definition of an unfair immigration-related practice under the Fair Employment and Housing Act to include threatening to file or filing a false report or complaint with any state or federal agency. The statute also clarifies that an employer cannot discriminate or retaliate against an employee who updates his/her personal information “based on a lawful change of name, Social Security number, or federal employment authorization document.”

Recommended Action Steps: Hospitals should revise their non-discrimination policies and provide updated training to staff involved in hiring or human resources functions.

Rest and Recovery Periods (SB 1360; Labor Code § 226.7)

Summary: Confirms that recovery periods required under the heat illness regulations are paid breaks and qualify as hours worked.

Recommended Action Steps: As this bill clarifies existing law, no new obligations are imposed. However, hospitals should ensure that employees subject to the heat
illness regulations are aware of the method to seek premiums under Labor Code § 226.7.

Non-Discrimination: Driver’s Licenses for Undocumented Persons (AB 1660; Government Code § 12926; Vehicle Code § 12801.9)

Summary: Expands the Fair Employment and Housing Act to prohibit employers from discriminating against an individual because he/she holds a driver’s license issued to an undocumented person. Employers may not require a person to present a driver’s license unless possessing a driver’s license is required by law or by the employer, and the employer’s requirement is otherwise permitted by law. Actions taken by an employer that are required to comply with federal I-9 verification requirements do not violate California law.

Recommended Action Steps: Hospitals should revise their non-discrimination policies and provide updated training to staff involved in hiring or human resources functions.

Cal/OSHA Citation Process (AB 1634; Labor Code § 6319, 6320, 6625)

Summary: Prohibits the stay of an abatement period during a pending appeal of a citation classified as a serious violation, repeat serious violation or willful serious violation. The bill would, however, authorize Cal/OSHA to stay these abatement periods, upon request, if the division determines that a stay will not adversely affect the health and safety of employees.

Recommended Action Steps: While this bill does not necessarily require any action by employers, it is important to note the trend to narrow employer appeal rights for Cal/OSHA citations.