Overview

- Executive Order on Price Transparency and Costs
- CY 2019 Outpatient Prospective Payment System (OPPS) Final Rule Recap
- FFY 2020 Medicare Post-Acute Care Payment Highlights
- CMS Draft Subregulatory Guidance – Ligature Risk and Co-Location
- Medicare Payment, Billing and Coverage Updates:
  - Changes to the Veterans Community Care Program
  - Specialty Care Models
- Request for Information: Patients over Paperwork
President Trump Issues Executive Order on Price Transparency June 24, 2019

- Executive Order addresses 5 areas on price transparency:
  1) Informing patients about prices
  2) Aligning and improving reporting on data and quality measures across settings through the creation of a Health Quality Roadmap
  3) Increasing access to data to make healthcare information more transparent and useful to patients
  4) Empowering patients by enhancing control over their healthcare resources
  5) Addressing surprise medical billing (Administration Principles May 2019)

Timeline for Implementing Executive Order

<table>
<thead>
<tr>
<th>TIMELINE</th>
<th>REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEPTEMBER</td>
<td>Proposed rule requiring hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services. Advance notice of proposed rule making to require healthcare providers, health insurance issuers and self-insured group health plans to provide information about expected out-of-pocket costs before patients receive care.</td>
</tr>
<tr>
<td>OCTOBER</td>
<td>Issue guidance to enhance patients' control over their healthcare resources by expanding their ability to select high-deductible health plans.</td>
</tr>
<tr>
<td>JANUARY</td>
<td>HHS report describing impediments to healthcare price and quality transparency and recommendations for eliminating these impediments. Secretaries of HHS, Defense and Veterans Affairs to develop a Health Quality Roadmap that aims to align and improve reporting on data and quality measures. Agencies must increase access to data in a more useful way for patients. HHS Secretary to submit report to President on additional steps needed to implement the Administration's principles on surprise medical billing.</td>
</tr>
</tbody>
</table>

CY 2020 Outpatient Prospective Payment System (OPPS) Proposed Rule – FORTHCOMING CY 2019 Recap!
CY 2019 OPPS Final Rule: Conversion Factor & Update Factor Component

<table>
<thead>
<tr>
<th>Conversion Factor</th>
<th>Final CY 2018</th>
<th>Final CY 2019</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPPS Conversion Factor</td>
<td>$78.636</td>
<td>$79.490</td>
<td>+1.09%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final CY 2019 Update Factor Component Value</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket (MB) Update</td>
<td>+2.90%</td>
</tr>
<tr>
<td>Affordable Care Act-Mandated Productivity MB Reduction</td>
<td>-0.6 percentage points (PPT)</td>
</tr>
<tr>
<td>ACA-Mandated Pre-Determined MB Reduction</td>
<td>-0.15 PPT</td>
</tr>
<tr>
<td>Wage Index Budget Neutrality Adjustment</td>
<td>-18%</td>
</tr>
<tr>
<td>Pass-through Spending / Outlier Budget Neutrality Adjustment</td>
<td>-2.10%</td>
</tr>
<tr>
<td>Cancer Hospital Budget Neutrality Adjustment</td>
<td>-0.65%</td>
</tr>
<tr>
<td>Overall Final Rate Update</td>
<td>+1.09%</td>
</tr>
</tbody>
</table>

CY 2019 OPPS Final Rule: Estimated Impact

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>2019 Estimated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Hospitals</td>
<td>0.6%</td>
</tr>
<tr>
<td>Urban – All</td>
<td>0.7%</td>
</tr>
<tr>
<td>Urban – Pacific Region</td>
<td>1.1%</td>
</tr>
<tr>
<td>Rural – All</td>
<td>0.9%</td>
</tr>
<tr>
<td>Rural – Pacific Region</td>
<td>-0.1%</td>
</tr>
</tbody>
</table>

CY 2019 OPPS Final Rule: Estimated Impact in California

<table>
<thead>
<tr>
<th>Impact Analysis</th>
<th>Bullion Impact</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated CY 2018 OPPS Payments</td>
<td>$25,322,530,000</td>
<td>-4.5%</td>
</tr>
<tr>
<td>ACA Mandated Market Basket Reductions</td>
<td>$(10,200,000)</td>
<td>3.23%</td>
</tr>
<tr>
<td>Other MB Adjustments</td>
<td>$(31,195,000)</td>
<td>0.22%</td>
</tr>
<tr>
<td>Wage Index</td>
<td>$19,321,000</td>
<td>0.17%</td>
</tr>
<tr>
<td>APC Factor Updates</td>
<td>$(1,950,000)</td>
<td>0.01%</td>
</tr>
<tr>
<td>Estimated CY 2019 OPPS Payments</td>
<td>$25,646,022,400</td>
<td>1.28%</td>
</tr>
</tbody>
</table>

Total Estimated Change CY 2018 to CY 2019: $547,492,400

Source: DHA Draft Rule Analysis, November 2018
Continue to pay for non-excepted services provided in non-excepted off-campus provider-based HOPDs at 40% of the OPPS rate
- CMS methodology remains unchanged, data updated
- CHA urged CMS to pay at 65% of OPPS rates
- Leave unchanged other site-neutral payment policies established for CY 2017 for:
  - Beneficiary cost sharing
  - Geographic payment adjustments
  - Partial hospitalization services continue to be paid at CMHC rates

60% reduction of payments for clinic visits furnished in excepted off-campus provider-based departments (PBDs) phased in over two years (i.e. pay at 40% of OPPS rate phased in over two years.)

Extension of 340B Drug Pricing Program payment cuts to non-excepted off-campus PBDs

Despite strong opposition from CHA and the hospital field, CMS finalized an expansion of its site-neutral payment policies:

- OPPS payments to 340B facilities for non-pass through drugs and biologicals (status indicator K) are reduced to average sales price (ASP) - 22.5% beginning CY 2018
- Children’s hospitals, PPS-exempt cancer hospitals, and rural sole-community hospitals continue to be paid at ASP + 6%
- For drugs acquired through the 340B program, non-exempt hospitals must report separately payable drugs with modifier “JG”, while exempt hospitals will use modifier “TB”
- Vaccines and drugs on pass-through payment status are excluded
CMS clarified that the reduction applies to all applicable drugs purchased under 340B, not just those with ASP pricing:

- Wholesale acquisition cost (WAC) drugs will be paid at WAC – 22.5% (instead of WAC+3%)
- Average Wholesale Price (AWP) drugs will be paid at 69.46% of AWP (instead of 95%).

In CY 2019, CMS will extend the payment reduction to those 340B drugs provided at non-excepted off-campus PBDs.

Currently biosimilars that are acquired under the 340B program and not on the pass-through payment list are paid at the biosimilar’s ASP – 22.5% of the reference product’s ASP.

CMS will instead pay for these biosimilars at ASP – 22.5% of the biosimilar’s ASP.

Currently only applies to HCPCS Q5101: Injection, filgrastim-sndz, biosimilar, (zanzio), 1 microgram

<table>
<thead>
<tr>
<th>Estimated Impact of ASP Change in Payment for Biosimilars Purchased Through the 340B Drug Pricing Program (Currently only HCPCS Q5101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Impact/Change in CY 2020 OPPS Revenue</td>
</tr>
<tr>
<td>96,146,709</td>
</tr>
<tr>
<td>95,149,700</td>
</tr>
<tr>
<td>89,837,709</td>
</tr>
</tbody>
</table>

What are we looking for?
- Application of AWI policies
- Expansion of site neutral policies
- EO Provisions on Price Transparency
- International Reference Pricing Model for Part B
FFY & CY 2020
Post-Acute Care Payment Highlights

IMPACT Act of 2014 Set the Wheels in Motion; Congress and CMS Piled On …

Source: Adapted from the AHA PAC Infographic, February 2019

FFY 2020 Proposed Rule Overview

SNF (proposed rule) IRF (proposed rule) LTCH (proposed rule) HHA (proposed rule)

Payment
Proposes to increase net payments by 2.5 percent, or $887 million, as compared to FFY 2019, the result of a 3 percent market-basket update, offset by a statutorily mandated 0.5 percent cut for productivity.


SNF VBP: Estimated decrease in payments $213 million to transition to a measure of potentially preventable hospital readmissions.

CHA Comment Letter
Proposes to increase net payments by 2.3 percent, or $195 million, as compared to FFY 2019, the result of a 3 percent market-basket update, offset by a statutorily mandated cut for productivity.

The update also reflects a proposed market basket rebasing.

Outlier threshold would increase from the current $9,402 to $9,935.

Using a different patient assessment instrument (“Section GG”) when assigning patients to a payment category.

CHA Comment Letter
Proposes an increase of 2.3 percent ($79 million), based on a 3.2 percent market basket increase, reduced by a statutorily required 0.5 percent cut for productivity, a 0.3 percent cut to reduce high-cost outlier (HCO) payments, and the second of three required adjustments to offset the permanent rescission of the "25 percent" rule.

CMS proposes an HCO threshold of $29,997.

CHA Comment Letter
Proposes a net decrease of 4.9 percent ($41 million) — largely due to the end of the transition period — and an HCO threshold of $26,994.

CMS proposes a change to a 30-day payment amount and includes an 8.01% cut to the base rate to offset behavioral assumptions of moving to PDGM.

Establish a permanent home infusion therapy benefit for 2021.

Phase out pre-payments for home health services.

Comments due September 9.

Quality Reporting Programs
2 news measures: Transfer of Health Information to the Provider AND Transfer of Health Information to the Patient.

Updates Discharge to Community measure to include nursing facility patients.

IRF and IPF Proposed rule updates

Hospital Area Wage Index to FFY2020.

### Proposed Standardized Patient Assessment Data Elements (SPADEs)

**Proposed SPADE Categories**

<table>
<thead>
<tr>
<th>Category</th>
<th>In FFY 2022</th>
<th>In CY 2022</th>
<th>Post of Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Function &amp; Mental Status</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Signs and Symptoms of delirium (CAM)</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>PHQ-2 to 9</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Medical Condition &amp; Comorbidity</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Impairments</td>
<td>X</td>
<td>X</td>
<td>Admission Only</td>
</tr>
<tr>
<td>Hearing**</td>
<td>X</td>
<td>X</td>
<td>Admission Only</td>
</tr>
<tr>
<td>Vision**</td>
<td>X</td>
<td>X</td>
<td>Admission Only</td>
</tr>
<tr>
<td>Special Services, Treatments and Interventions (SSTI)</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Nutritional approaches: IV or feeding tube, diet, etc.</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Services and Treatments: Cancer, respiratory, other (IV medications, transfusions, dialysis, etc.)</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>High-Risk Drug Classes (Use and Indication)</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Social Determinants of Health (proposed creation of new category)</td>
<td>X</td>
<td>X</td>
<td>Admission Only</td>
</tr>
<tr>
<td>Race**</td>
<td>X</td>
<td>X</td>
<td>Admission Only</td>
</tr>
<tr>
<td>Ethnicity**</td>
<td>X</td>
<td>X</td>
<td>Admission Only</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Transportation (PRAPARE)</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
<tr>
<td>Social Isolation (PROMIS)</td>
<td>X</td>
<td>X</td>
<td>Admission &amp; Discharge</td>
</tr>
</tbody>
</table>

*Beginning with FFY 2023, admission and discharge data to be reported from subsequent calendar year (Jan. 1-Dec. 31, 2021 for FFY 2023, Jan 1.-Dec. 31, 2022 for FFY 2024).**

**Admission only data submission – deemed unlikely that assessment will have changed between admission and discharge.**

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### CHA Comments on SPADE

In comments, CHA urged CMS to:

- Reduce the speed and scope of SPADE implementation
- Create and make transparent a data use strategy and analysis plan to better understand how the agency will further assess SPADEs’ adequacy and usability in the development of a unified PPS and future quality measures
- Develop a framework in the patient assessment tools for prioritizing implementation of the critical SPADEs
- Detail and adopt a staged implementation plan to allow additional time to manage the operational and workflow changes needed to ensure reliable and valid data collection across all patients

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### Hospital/Post-Acute Care Considerations

- PAC PPS changes will have significant upstream and downstream implications in future years
  - Changes in admission criteria by PAC providers
  - Significant resource/operational constraints
  - Disruption in target pricing for Advance Payment Models in out years
  - Significant CoP changes in process for SNFs, HHAs
- Significant changes slated for SNF, IRF and HHA PPS
- SPADE and Payment System Change (SNF, HHA and IRF)
  - Likely creating operational challenges, but positions agency to more alignment on unified PAC PPS
  - Behavioral offsets – Home Health!
- Lack of transparency from agency regarding data
- Engage and prepare, understand what is happening outside your walls as it will impact operation
Inpatient Rehabilitation Facility Appeals Settlement Options

- CMS will settle IRF Medicare appeals that were filed by Aug. 31, 2018 if the appeal is currently pending or eligible for further appeal at the MAC, quality improvement contractor, Office of Medicare Hearings and Appeals and/or Medicare Appeals Council review level.
- CMS will pay 69% of net payable amount for most claims
- CMS will pay 100% for claims denied solely because justification for group therapy was not documented in the medical record or threshold of therapy time (Three-Hour Rule) was not met
- National Provider call on the settlement appeals process scheduled for August 13
- Provider Deadline is August 31, 2019

CMS Draft Guidance on Ligature Risk & Co-location Policies (Conditions of Participation)

- Issued by CMS on April 19 to clarify its ligature risk policies for inpatient psychiatric hospitals and psychiatric hospital units
- No timeline for CMS to finalize guidance
- Clarifies existing 2017 ligature risk interpretive guidelines
- Differentiates between locked and unlocked psychiatric units
- Establishes a Ligature Risk Extension Request Process
- Requires education and training for hospital staff
- Revises certain surveyor-specific procedures
- Does NOT permit waivers for findings of ligature risk
- The presence of unmitigated ligature risks may present an immediate jeopardy situation
In comments, CHA urged CMS to:

- Limit the scope of ligature risk restraint requirements to locked psychiatric units within psychiatric and acute care hospitals
  - Remove any reference to emergency departments
  - Focus should be on patient assessment
- Develop – with stakeholder input – extensive surveyor education to ensure consistent and effective interpretation of the requirements
- Clarify ligature risk extension requirements; accountability

**Draft Co-location Guidance**

- Issued by CMS on May 3 regarding co-location policies for hospitals that share space, staff or services with another hospital or health care entity
  - No timeline for CMS to finalize guidance
- Discusses compliance with Conditions of Participation in relation to:
  - “Clinical space” and “public space”
  - Contracted services
  - Staffing contracts
  - Emergency services
  - Changes to survey procedures

In comments, CHA urged CMS to:

- Think strategically about how to increase flexibility in distinct and shared spaces in the context of both patient safety and affordability
- Consider policies and procedures that address a limited number of shared staff exceptions as outlined in the draft policy
- Clarify shift and training requirement for the contracted services
- Allow hospitals to contract with a co-located hospital for specialized teams, such as emergency response teams
- Consider a period of education and non-enforcement
- Consider Ligature Risk Extension Request type of process, as well as a limited exceptions process or “grandfathering” of shared space arrangements
Specialty Care Models

Specialty Care Models Proposed Rule

- CMS issued a proposed rule that would establish two new mandatory payment models
  - Radiation Oncology (RO) Model
  - End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model
- CHA currently reviewing rule; seeking member input
- Comments are due September 16
- CMS also announced four new voluntary kidney care models

Radiation Oncology Model

- Model will provide participants with prospective, site-neutral, episode-based payment amounts for radiation therapy services furnished during a 90-day episode of care; 17 types of cancer
- Participation will be required of hospital outpatient departments, physician group practices and freestanding radiation therapy centers in randomly-selected core based statistical areas (CBSAs)
- CBSAs will be randomly selected to include about 40 percent of radiation episodes; CBSAs will be announced with publication of the final rule
- Qualifies as APM for QPP program for physicians
- Model performance period would begin in January or April 2020 and end December 31, 2024
Radiation Oncology Model (cont.)
- Testing to determine if a shorter course of RT with more radiation per episode visits would improve quality, patient experience and lower costs.
- CAH's and PPS exempt cancer hospitals are excluded from mandatory model.
- Episode begins with initial treatment and planning phase furnished by the treating professional.
- Providers share in full risk – both upside and downside risk.
- 4 quality measures and additional clinical documentation required through a portal.
- Waivers include site neutral payment policies for non-excepted PBD.
- Eight step process for establishing the episode target price; utilizing HOPD data.

End-Stage Renal Disease (ESRD) Treatment Choices Models
- Model will provide incentive to encourage dialysis in the home.
- Participants would include ESRD facilities and managing clinicians in randomly-selected Hospital Referral Regions with an aim to cover 50 percent of Medicare ESRD beneficiaries.
- Two Payment Adjustments:
  - Uniform positive adjustment on Medicare claims for home-dialysis and home-dialysis related services.
  - Positive or negative adjustments on home- and in-center dialysis claims based on home-dialysis rates and transplant rate performance.
- Performance Period January 1, 2020 – June 30, 2026.

Request for Information: Reducing Burden Through Patients over Paperwork Initiative
RFI on Reducing Provider Burden

- CMS issued a request for information seeking innovative ideas to relieve burden and build on agency efforts to put patients over paperwork.
- Comments are due August 12.
- CHA seeks your input on regulatory policies that would reduce burden on hospitals.

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RFI on Reducing Provider Burden

CHA is considering offering ideas including – but not limited to – the following:

- Improve S-10 Audit Process to Reduce Burden
- Rescind Appropriate Use Criteria Facility Reporting Requirements
- Rescind Clinical Laboratory Fee Schedule Hospital Outreach Laboratory Reporting Requirements
- Rescind Exact Match Requirements for Multiple Service Locations
- Permanent Enforcement Moratorium of Direct Supervision Requirements
- Reduce Burden of Obtaining DME
- Continue to reduce quality reporting burden and remove Five Star rating system
- Limit the timing and pace of regulatory change, including for subregulatory guidance and CoP interpretive guidelines

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Currently Under Review at OMB

- All FY final rules
- Stark and Physician Self Referral Proposed Rules (Regulatory Spring)
- Coordinating care and information sharing on substance abuse
- Public Charge Final Rule
- International Reference Pricing Model for Part B Proposed Rule
- Discharge Planning Final Rule

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CMS Delays Billing Edit Requiring Exact Matching for OPPS Providers With Multiple Service Locations

- CMS postponed activation of billing edits requiring exact matching for the address on claims data for outpatient prospective payment system providers with multiple service locations.
  - Edits will now be implemented in October 2019.
  - Claims that do not exactly match will be returned.
  - During testing, CMS found that minor discrepancies, such as writing the word “road” versus abbreviating it to “Rd.,” would have resulted in returned claims.
  - Providers should ensure claims data exactly match.

Appropriate Use Criteria (AUC) Program

- Protecting Access to Medicare Act (PAMA) of 2014 required CMS to create a program promoting use of AUC for advanced diagnostic imaging
- Restricts payment for furnishing professional to claims that indicate that ordering professional consulted with qualified clinical decision support mechanism (CDSM)
- Applies only in “applicable settings”
  - Hospital outpatient departments, physician offices, ambulatory surgical centers, and independent diagnostic testing facilities
AUC Implementation Timeline

- CY 2016 PFS Rule: Definition of AUC and process for development
- CY 2017 PFS Rule: Definition of CDSMs and associated requirements
- July 13, 2017: Release of first list of qualified CDSMs
- CY 2018 PFS Rule:
  - Voluntary reporting period (July 2018 – Dec. 2019)
  - Delayed start date (Jan. 1, 2020)
  - Educational and operations testing year (2020)
- Future rulemaking will address identification of outlier ordering professionals

Reporting AUC Consultation Information

- Payment for applicable imaging service: only if claim for service includes certain information about AUC consultation
- Beginning Jan. 1, 2020, CMS requires AUC consultation information be reported on all claims, from both furnishing professionals and facilities
- CMS finalized G-codes and modifiers as the mechanism to report AUC information on Medicare claims
  - "QQ" modifier is currently used to indicate voluntary AUC reporting

Clinical Lab Fee Schedule (CLFS) Payments

- PAMA law requires CMS to set CLFS payments for laboratory services using weighted median of private payer payment rates.
- Law requires certain “applicable laboratories” to collect and report private payer rates every 3 years.
  - “Majority of Medicare revenue” test – previously excluded most hospital labs
  - “Low expenditure threshold” test – excludes most physician office labs
- CMS implemented the new CLFS rates in 2018
- Stakeholder concerns about too few labs being required to report (especially hospital labs) resulting in significant payment cuts under CLFS
- Vast majority of Medicare payments for hospital lab services packaged into the OPPS and IPPS. Not subject to the new CLFS rates.
- Hospital laboratories that provide “outreach testing” are paid under CLFS for these services
Revisions to Definition of Applicable Laboratory

- 2018 CMS Final Rule made two revisions to the regulatory definition of “Applicable Laboratory”, effective January 1, 2019
  1) Medicare Advantage plan payments are excluded from total Medicare revenues (the denominator of the majority of Medicare revenues threshold)
  2) Hospital outreach laboratories that bill for their non-patient laboratory services using the hospital’s NPI must use Medicare revenues from the Form CMS-1450 14x Type of Bill (TOB) to determine whether they meet the majority of Medicare revenues threshold and low expenditure threshold
- Low-expenditure threshold remains $12,500 in Medicare CLFS Revenues in the data collection period

Considerations for Hospital Laboratories that bill using 14x TOB

- Hospitals with laboratories that bill using the 14x TOB should be prepared to determine their status as an applicable laboratory
  - If a hospital has more than $12,500 Medicare revenue billed from Jan. 1 – June 30 on a 14x TOB the laboratory is likely to be defined as an “applicable laboratory”
  - The hospital would be required to report applicable private payer data on all laboratory tests attributed its outreach service line (services for non-patients)
  - Hospitals are required to develop processes to identify and report on payment rates for private payors that do not require billing on a 14x TOB
- Reporting period begins Jan. 1, 2020

Veterans Community Care Program
Veterans Community Care Program

- Department of Veterans Affairs finalized regulations implementing the Veterans Community Care Program effective June 6
- Third-Party Administrator (TPA) will be selected to develop and administer new community care networks
  - California’s TPA (Region 4) has not yet been selected
  - Hospitals that currently participate in the Veterans Choice Program under an existing contract administered by the TriWest Healthcare Alliance can continue to provide care to veterans that meet eligibility requirements under the new program until the new contracts are established
- VA will implement prompt payment requirements in separate rulemaking

Questions?

Raise your hand or submit a question at www.menti.com and enter code 29 15 36

Contact

For additional questions, please contact me!

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