Proposed Rules on Interoperability of Health Information
Background

- HHS released 2 proposed rules intended to improve interoperability of electronic health information
  - Issued by Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC)
  - Comments due to CMS and ONC mid-April

Overview of Proposals

- Revise Conditions of Participation (CoPs) for hospitals to require electronic notifications for admission, discharges and transfers
  - Require payers in CMS programs to make patient claims and other health information available to patients through third-party applications and developers
    - Applies to Medicare Advantage organizations, Medicaid and CHIP state agencies, Medicaid and CHIP Managed Care Plans and Qualified Health Plans on Federally Facilitated Exchanges
  - Require these payers to participate in trusted exchange frameworks that allow for participation in any health information network

Overview of Proposals (cont’d)

- Publicly report clinicians and hospitals found to participate in information blocking
- Outline seven proposed exceptions to information blocking definition as required by 21st Century Cures Act
- Update 2015 edition health IT certification criteria to promote the adoption of standardized application programming interfaces
Proposed Updates to Conditions of Participation

- CMS proposes to require electronic patient event notifications of inpatient admissions, discharges and transfers (ADT) as a CoP for Medicare and Medicaid.
- Applies to Acute, Long-Term Care, Rehabilitation, Psychiatric, Children’s, Cancer and Critical Access Hospitals.
- CMS proposes to limit the requirement to hospitals that have an electronic health record (EHR) with specific technical capability to generate and transmit ADT information.
- CMS seeks input on how to implement proposal as part of survey and certification guidance, as well as what is a reasonable timeframe for implementation by hospitals.

Past RFI on Promoting Electronic Interoperability

- In the FY 2019 Medicare payment rules, CMS requested feedback on promoting electronic interoperability.
- CHA opposed revisions to the Medicare CoPs that would require electronic exchange of health information.

Requests for Information (RFIs) in CMS Rules

- CMS requests input on how it can promote wide adoption of interoperable health IT systems for use across health settings, including post-acute care.
- CMS seeks feedback on how the agency can leverage its authority and private sector efforts to address patient matching issues.
- ONC seeks feedback on the definition of electronic health information and the implications of including price information within the scope of that definition.
Challenges and Barriers to Interoperability

- CMS acknowledges lack of adoption of certified health IT among PAC providers due in part to not being eligible for Promoting Interoperability Programs (formerly EHR Incentive Programs)
- Seeks input on how the adoption of interoperable health IT systems and use of interoperable data across settings such as PAC can be more broadly incentivized
- Seeks input on how Innovation Center models can help advance progress towards interoperability
- CHA is seeking member input in March!

Medicare Audit Updates

Medicare Contractors

- Recovery Audit Contractors (RAC)
  - Identify improper Medicare payments made on healthcare claims
  - California Region 4:
    - Program Overview
  - Noridian:
    - Program Overview
- Supplemental Medical Review Specialty Contractor (SMRSC)
  - Conducts medical reviews as directed by CMS
- Zone Program Integrity Contractor (ZPIC)
  - Investigates instances of suspected fraud, waste, and abuse
- Quality Improvement Organization (QIO)
  - Reviews appeals and complaints about health care for Medicare recipients; short stay reviews
  - Livanta:
    - Program Overview
MAC Targeted Probe and Educate (TPE)

- Bulletin issued September 2017: Targeted Probe and Educate Pilot (rolling out nationwide)
- Noridian Targeted Probe and Educate (TPE) Pilot
- TPE Q&A’s
- Applies to all medical review
- The TPE review process includes three rounds of a prepayment probe review with education. If there are continued high denials after the first three rounds, Noridian will refer the provider and results to CMS.
- CMS Central Office will determine additional action, which may include extrapolation, referral to the Zone Program Integrity Contractor, referral to Recovery Auditor Contractor, etc.

TPE (cont’d)

- Noridian is targeting CERT errors
  - Example: Hip and Knee replacements
  - IRF Medical Necessity, Outpatient Claims
- Providers should always comply with provider education provided and make it an organizational priority
- Everyone should participate in education!
- Avoid referrals to other contractors, there is no process articulated for coming back to regular TPE processes!
- Flag inconsistent guidance for CHA

Therapy Student Supervision

- CMS has recently affirmed existing policy that therapies provided by students under direct supervision are billable and may be counted toward compliance with the inpatient rehabilitation facility (IRF) intensive therapy requirement (3 hours/day).
- Some electronic medical records (EMRs) may not provide clear evidence that the direct supervision requirement was met, leading to payment denials.

http://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Supervision/CMSClarificationTherapyStudentsinHospitals_121818.pdf
Short Stay Reviews of TKA

- New MLN Article Released Jan. 24

Post-Acute Care Payment Rules and Progress on the Unified Post Acute Care PPS
Looking Back as We Look Forward…

Level Set: Post-Acute Payment & Reimbursement Today

- Most PAC services are paid for by Medicare FFS or Medicare Advantage, and each PAC setting has its own Medicare FFS payment system and patient assessment tool.

  - HHA
    - 60-day Episode
    - Paid through HRRG
    - Amount determined by acuity
  - SNF
    - Per Diem Payment
    - Paid through RUG
    - Amount determined by acuity
  - IRF
    - Episodic Payment
    - Paid through RUG
    - Amount determined by condition and functional status
  - LTCH
    - Episodic Payment
    - Paid through LTCH-DRG
    - Amount determined by diagnosis

Source: Premier
Level Set: Concept of a Unified PAC PPS in the Future

- Eliminate silos and pay a case mix adjusted rate that reflects the acuity and characteristics of the patient rather than the setting of care
  - Requires standardized data collection across all settings to determine patient characteristics and acuity
  - Often referred to as “site neutral” but its very different from site neutral in the hospital setting
  - Align incentives and eliminate regulatory barriers (common set of COPs)

Medicare Fee-for-Service Post-Acute Expenditure

Growth in Medicare’s Fee-for-Service Post-Acute Care Expenditures has Slowed Since 2002 (2001-2015, in billions USD)

Post-Acute Use & Spend is Highly Variable
Address Excessive Payment for PAC Providers by Establishing a Unified Payment System Based on Patients’ Clinical Needs Rather than Site of Care

- For FFY 2019 to FFY 2023, the four primary PAC settings, including SNFs, HHA, IRFs and LTCHs, will receive a lower annual Medicare payment update.
- Beginning in FFY 2024, this proposal implements a unified post-acute care payment system that spans these settings, with payments based on episodes of care and patient characteristics rather than the site of service.
- Rates for the provider types included in this proposal are updated on a fiscal year basis, including those whose payment systems are currently updated on a calendar year basis.
- The first year of implementation is required to be budget neutral relative to estimated payments that would otherwise have been paid in FFY 2024 absent this change.


- Adds hospice to existing post-acute transfer policy beginning Oct. 1, 2018
  - Hospitals would be paid less upon transfer to hospice for short hospital stays (-$4.895 billion)
- Extends the LTCH current blended rate applied to site-neutral cases for two years, and implements a MB reduction of 4.6% for FFY 2018 thru 2026
- Sets the SNF rate update at 2.4% for FFY 2019
- Five-year extension for home health rural add-on with modifications to payment targeting (-$375 million)
- Sets the home health increase to 1.4 percent in FFY 2020 (-$3.5 billion); requires budget neutral reform of home health payment system beginning Jan. 1, 2020


- Requires CMS to undergo rulemaking to propose and finalize revised payment system by Jan. 1, 2020
  - Reduces the unit of a home health episode from 60 to 30 days
  - Requires revision to current case-mix system and elimination of the use of therapy thresholds
  - Home health payments will be revised to ensure reform is budget neutral
**Balanced Budget Act of 2018 – Key PAC Provisions**

- Permanently repeals outpatient therapy caps beginning on Jan. 1, 2018 (+$6.47 billion)
- Continues to require modifier on claims over the current exception threshold indicating medical necessity; lowers the threshold for targeted manual medical review process to $3,000
- Offset includes reduction in payment to Part B therapy services furnished all or in part by a physical and occupational therapy assistant

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**The Journey to a Unified PAC PPS**

Congress and the administration have shared goals: lower health care expenditures, increase efficiencies, and transform care delivery for beneficiaries.

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**Current Program Measures by Impact Act Domains**

<table>
<thead>
<tr>
<th>IMPACT Act Domains</th>
<th>IRF QIP</th>
<th>LTCH QIP</th>
<th>HPF QIP</th>
<th>SNF QIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin integrity and changes in skin integrity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Functional status, cognitive function, and changes in function and cognitive function</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Incidence of major falls</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transfer of health information and care preferences when an individual transitions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Resource use measures, including total estimated Medicare spending per beneficiary</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Discharge to community</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>All-cause risk-adjusted potentially preventable hospital readmissions rates</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Early Findings from National Beta Test of Candidate Standardized Patient Assessment Data Elements (SPADEs)

Building Blocks for Unified PPS

Quality Measure Development

Interoperability

Standardized Patient Assessment Data Elements

- Each setting has its own patient assessment tool, and CMS is testing new data elements to be added across all tools. Commonly referred to as the SPADE elements.
- Many of the data elements implemented to date across the payment assessment tools are used in the calculation of quality measures for each of the respective quality reporting programs (i.e. functional status).
- All data elements are also required to be interoperable.
Categories Identified for Standardization in the IMPACT Act

- Function (e.g., self care and mobility)
- Cognitive function (e.g., express & understand ideas; mental status, such as depression and dementia)
- Special services, treatments & interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
- Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
- Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
- Other categories

Consensus Vetting Activities

- Technical Expert Panel
  - Sept. 2015
- Special Open Door Forum
- Public Comment Periods
- Public Comment Periods for FY 2018/19
  - Monthly Open Forum
  - Rule
- Small Group Discussions with PAC Associations
- Dialogues with Clinical Staff

Project Phases: SPADE Development and Testing

- Information Gathering
- Pilot Testing (Alpha 1 & 2)
  - Aug. 2016-July 2017
- National Beta Testing
  - Nov. 2017-Sept. 2018
- Data Analysis and Reporting Results
  - Sept. 2018-Sept. 2019
- Preliminary Findings of the Beta Test
  - Released in October 2018

Source: CMS/RAND Corporation

Visit CMS website for more information:
Data Element Categories Tested in Beta

- Cognitive Status
- Mental Status
- Medical Conditions: Pain
- Impairments: Vision and hearing; Continence
- Special Services, Treatments, and Interventions (SSTI)
- Other
  - Care Preferences
  - Global Health
  - Medication Reconciliation

Source: CMS/RAND Corporation

Beta Test Markets

Source: CMS/RAND Corporation

Sample Sizes

<table>
<thead>
<tr>
<th>Participating Providers</th>
<th>HHA</th>
<th>IRF</th>
<th>LTCH</th>
<th>SNF</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35</td>
<td>23</td>
<td>25</td>
<td>60</td>
<td>143</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communicative Assessments</th>
<th>HHA</th>
<th>IRF</th>
<th>LTCH</th>
<th>SNF</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Total</td>
<td>653</td>
<td>794</td>
<td>507</td>
<td>1167</td>
<td>3121</td>
</tr>
<tr>
<td>IRR</td>
<td>199</td>
<td>261</td>
<td>242</td>
<td>274</td>
<td>976</td>
</tr>
<tr>
<td>3,5,7 Repeat</td>
<td>112</td>
<td>150</td>
<td>91</td>
<td>239</td>
<td>592</td>
</tr>
<tr>
<td>Discharge</td>
<td>148</td>
<td>349</td>
<td>91</td>
<td>235</td>
<td>823</td>
</tr>
</tbody>
</table>

Source: CMS/RAND Corporation
RAND: Key Takeaways from Beta Test

- Data element performance
  - Reliability – Strong reliability across settings and across data elements – very few areas of concern and no “red flags”
  - Feasibility – Very little missing data
- Results of repeat assessment tests (a.k.a. “lookbacks”)
  - Repeat assessment of patient interview items on admission days 3, 5 and 7 showed very little variation in responses across days
  - Recording of presence/absence of chart review items based on chart information present at admission days 1, 3, 5 and 7 showed that the majority of information was present in the chart on day 1

General Evaluation of Candidate SPADEs

CHA Comment Letter

- CHA submitted comments to CMS on the preliminary findings
- In the letter, CHA:
  - Urges CMS to release the beta test data set so that other stakeholders can conduct analysis for the agency’s consideration
  - Raises concerns about the patients for whom data was not collected, particularly those with cognitive impairments or whose primary language is not English
- CHA will continue to engage with CMS and members on these and other important issues.
Next Steps: SPADE

- Anticipated inclusion of multiple beta SPADE elements proposed across all patient assessment tools in FFY 2020 rule making; effective dates TBD
- In previous rulemaking, CMS noted it would revisit for FFY 2021
- Release of multiple technical reports for review and comment leading up to rulemaking and throughout 2019
- Final report on beta test slated for September 2019, but this may be delayed
- If proposed and finalized, data collection could begin as early as October 2019 (IRF, LTCH and SNF) or January 1, 2020 for Home Health Agencies.

The Trajectory Played Out in 2019 Rulemaking

<table>
<thead>
<tr>
<th>Payment Setting</th>
<th>Rate Update</th>
<th>Setting-Specific Payment Adjustments</th>
<th>Pay-For-Reporting Programs</th>
<th>Other Notation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF (final rule)</td>
<td>+0.2%</td>
<td>Significant case mix adjustment change from RUGS-IV to PDPM for FY 2019 (FY 2020).</td>
<td>VBP beg FFY 2019 providing incentive payments to SNFs with levels of performance and penalties of up to 2% on performance in specialties, low-volume SNFs be assigned a break-even performance score in SNF VBP. For SNF QRP, increase data from 1 to 2 years for calculation and D/C to community.</td>
<td>Increased stay policy that treats a case that leaves a SNF for 4 or more days and then returns as a new admission, which would be initiated with a new patient assessment. Patients returning within 3 or fewer days would be subject to prior payer classification with an adjustment to the variable per diem rate.</td>
</tr>
<tr>
<td>IRF (final rule)</td>
<td>+1.16%</td>
<td>Removed the FIM instrument and associated function modifier from the IRF-PAI beginning Oct 1, 2019 (FFY 2020).</td>
<td>Post-admission MD evaluation may count as 1 of the 3 face-to-face visits, rehab MDs may lead the team mtgs remotely w/o any add’l documentation, and removed requirement for admission order documentation.</td>
<td>Removed 1 measure in FFY 2020 and 1 in FFY 2021. Publicly display assessment-based measures.</td>
</tr>
</tbody>
</table>

SNF PPS

- Changes to the case mix adjustment model reflective of MedPAC recommendations to realign incentives for SNFs be rewarded for the more clinically complex patients often cared for in the hospital-based setting
- 4 years in the making, multiple TEP reports and data analysis to support transition
- Budget Neutral
- No behavioral offsets ….. yet
Limitations in Measuring Functional Outcomes - IRFs

- CY 2019 IRF PPS final rule finalized removal of FIM tool and use of Section GG functional status items in FIM's place to inform IRF CMGs
- While significant payment challenges and a shift for IRFs, replacement of the FIM with Section GG is laying the ground work for unified PAC PPS
- All PAC settings use most Section GG items
  - LTCHs do not use 4 self-care items, 6 mobility items; only setting to use certain self-care item
- Items have questionable validity/reliability
  - Developed as part of PAC-PRD in 2008
  - Items may not capture full resource needs of high acuity patients
- Stakeholders including AHA will continue to raise concerns with CMS, caution against relying upon Section GG data in unified PAC PPS case mix group methodology

Post-Acute Rule Updates Cont.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Rule Update</th>
<th>Setting-Specific Payment Adjustments</th>
<th>Pay-For-Reporting Programs</th>
<th>Other Notables</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td>+0.16% (2.7% MB - 1.55 PPT ACA)</td>
<td>Transitional blended DRR rate over 25% Threshold, and apply 25% adjustment to the LTCH PPS rate. The comparable amount for SN and FFY 2019.</td>
<td>Removes 2 measures in FY2020 and 1 measure in FY2021.</td>
<td></td>
</tr>
</tbody>
</table>

MedPAC Mandated LTCH Report – Due June 2019

- Pathway of SGR Reform Act of 2013 required MedPAC to examine the effect of the dual-payment rate structure on:
  - Different types of LTCHs
  - The growth in Medicare spending for services in such hospitals
  - The use of other PAC care and hospice care settings, and
  - The quality of patient care in LTCH hospitals
LTCH Report Key Findings – November 18 Meeting

- Dual payment system not fully phased in presenting several analytical and data challenges
- The share of LTCH cases that meet criteria has increased, the volume of those that do not had decreased
- More than 40 facilities have closed, many with low occupancy rate, low share of cases that met criteria and higher costs than other facilities
- Changes in supply or use of PAC or hospice providers have been minimal
- Negligible change in LTCH quality

FFY 2019 Key Themes

- PAC PPS: Delayed any additions to the patient assessment items, but quality measurement development continues
- Removal of quality measures that were duplicative across all PPSs
- Significant changes in SNF and IRF PPS
  - Likely to coincide in future years with additional patient assessment items
  - Likely creating operational challenges, but positions agency to more alignment on unified PAC PPS
- Lack of transparency from agency, stakeholders continue to request release of data
- Tipping point is near

New Quality Measures Under Consideration For FY2020 Rulemaking

- MAP reviewed eight measures under consideration for four PAC/LTC quality reporting programs
- Two measures in each setting (HH, SNF, IRF and LTCH) addressing the transfer of health information.
- The measures assess the ability to transfer health information to either the next provider of care or to the patient and/or caregiver. Testing Report Released Jan, 2019
- February 2019 Recommendation to CMS Conditional Support
- MAP noted that these measures are important assessments of interoperability and the ability of providers to transfer information, specifically a medication list. However more work to be done including further defining medication lists. [http://www.qualityforum.org/map/]
**Recommendations for 2020 Payment Updates**

<table>
<thead>
<tr>
<th>Inpatient and Outpatient Hospitals</th>
<th>Payment Update Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create new Hospital Value Incentive Program</td>
<td>2 percent</td>
</tr>
<tr>
<td>Consolidate HVBP, RRP, and HAC Penalty Program while also eliminating the Inpatient Quality Reporting Program</td>
<td>2.0 percent</td>
</tr>
</tbody>
</table>

| Inpatient Rehabilitation Facilities | - 6.0 percent |
| Skilled Nursing Facilities | 0 percent |
| Ambulatory Surgical Centers | 0 percent |
| Hospice | -2 percent |
| Home Health | -5 percent |

**In Summary…**

- Anticipate SPADE in patient assessment tools
- Continued refinement of all PAC PPS
- Implementation of Transfer of Patient Information Quality Measure
- Maybe a final rule on discharge planning (Delayed in October 2018)
- Don’t rule out congressional action to achieve budget savings, reintroduction of legislation on PAC value based purchasing or additional transparency requirements

Payment Model Features
- Common unit of service (i.e., a stay or episode) with a patient characteristic risk-adjustment system.
- Payment adjustment to reflect lower costs in HHA settings.
- Separate payments for routine and therapy services and for non-therapy ancillary services such as drugs.
- Outlier policies for unusually high-cost stays and unusually short stays.

MedPAC Recommendations on Unified PAC PPS
- Unified PAC PPS could establish accurate and unbiased payments
  - 2016 Recommendation: PPS design features outlined
- PAC PPS could be implemented sooner than contemplated in IMPACT Act
  - 2017 Recommendation: Begin implementation in 2021
- Aggregate level of Medicare payments for PAC is high
  - 2017 Recommendation: Lower PAC PPS payments by 5%
- Increase the equity of PAC payments before PAC PPS is implemented
  - 2018 Recommendation: Blend the current setting-specific relative weights and PAC PPS relative weights to correct biases in current payment systems and begin in FFY 2019

MedPAC 2018 Transition Recommendation

<table>
<thead>
<tr>
<th>Implementation Period</th>
<th>HHA</th>
<th>SNF</th>
<th>LTCH</th>
<th>IRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blend setting specific and Unified PPS relative weights for FFY 2019 and 2020</td>
<td>Redistribution Payment</td>
<td>Redistribution Payment</td>
<td>Redistribution Payment</td>
<td>Redistribution Payment</td>
</tr>
<tr>
<td>Transition to a unified PPS in FFY 2021</td>
<td>Redistribution payments across settings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: MedPAC, December 2017 Meeting
The MedPAC Train Is Not Slowing Down

2019/2020 MedPAC Agenda

- Consideration of sequential PAC stays and how to define and pay for them accurately
- Define and develop measures and VBP methodology under Unified PPS
- Recommendations regarding how best to assist beneficiaries in picking PAC providers at discharge

New MedPAC Focus

- MedPAC (Nov. 2018) questioned accuracy of PAC-reported functional data
- Cited mismatch between severity at discharge from STACH (based on SOI, LOS, cost) and severity at admission at proximal PAC stay (based on IRF-PAI)
- Claims-based measures improved less than OASIS-based measures
- Plan to engage in multiple analyses to determine “accuracy” (i.e. consistency) for June 2019 Report

AHA Evaluation of MedPAC Prototype

- The evaluation report, “A Critique of MedPAC’s Post-Acute Care Prospective Payment System Prototype,” highlighted several fundamental concerns with the MedPAC prototype:
  - The model is, in part, built using very old cost data, which raises questions about the prototype’s accuracy in predicting costs given the current post-acute care scenario in which all four settings are presently treating sicker patient populations, on average. Significant changes for 2020 are in process, which could make the prototype even more dated.
  - The prototype’s reliance on a 100 variable regression model diminishes its practical use.
  - The report also raises access concerns for high-acute, high-cost post-acute care patients whose resource are least likely to be captured by the prototype.
ASPE Work is Just Getting Started – Report due to Congress 2022

- September 2018 TEP Meeting; RTI Requested input
- AHA Priorities for PAC PPS Model sent in a letter to RTI on February 15
- PAC PPS Baseline Must Reflect 2020 PAC Reforms
- Keep the prototype simple and be transparent
- Pair any changes in payment with regulatory relief
- Disregard the unworkable MedPAC timeline

POST-ACUTE CARE REFORMS TIMELINE

Hospital/PAC 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, HHA
- Significant changes slated for BNF, IRF and HHA PPS
  - Likely to coincide in future years with additional standardized patient assessment data elements (SPADEs) in tools
  - Likely creating operational challenges, but positions agency to more alignment on unified PAC PPS
  - Behavioral offsets – something to watch
- Lack of transparency from agency regarding data
- Engage and prepare, understand what is happening outside your walls as it will impact operation
Questions?

THANK YOU!

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Washington, D.C.

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