AGENDA
COMMUNITY HEALTH SERVICES BOARD
Cordova Center – Library Education Room
APRIL 14, 2016 at 7:00PM
REGULAR MEETING

AT CCMC, WE BELIEVE THAT HEALTHY PEOPLE CREATE A HEALTHY COMMUNITY.

Board Members

President:
David Allison
Term expires 03/19

Vice-President: Tim Joyce
Term expires 03/17

Secretary:
Tom Bailer
term expires 03/17

James Burton
term expires 03/19
Joshua Hallquist
term expires 03/18
Robert Beedle
term expires 03/18
James Wiese
Term expires 03/19

Interim CEO
Noel Rea

OPENING

1. Call to Order
2. Roll Call – David Allison, Tim Joyce, James Burton, Tom Bailer, Josh Hallquist, Robert Beedle and James Wiese.
3. Establishment of a Quorum

A. APPROVAL OF AGENDA

B. CONFLICT OF INTEREST

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS

1. Guest Speaker
2. Audience Comments (limited to 3 minutes per speaker).
   Speaker must give name and agenda item to which they are addressing.

D. APPROVAL OF CONSENT CALENDAR Pgs. 1-27

1. RAD P018 – Intravenous Contrast Administration
2. RS P102 – Exercise Guidelines
3. RS P103 – Safe Lifting
4. RS P105 – Electrical Stimulation
5. RS P106 – Gait Belt for Transfers
6. RS P201 – Transcutaneous Electrical Nerve Stimulation (TENS) Unit
7. RS P202 – Operation of Rehabilitation Services Equipment
8. RS P203 – Hydrocollator Cleaning
9. RS P204 – Temperature Checks of the Hydrocollator
10. RS P206 - Ultrasound

E. APPROVAL OF MINUTES Pgs. 28- 30

1. Minutes from the March 10, 2016 Regular Meeting

F. REPORTS OF OFFICER and ADVISORS

1. President's Report -
2. Administrator's Report - **Pgs. 31-32**
3. Finance Report – February Financials **Pgs. 33-35**
4. Medical Director's Report -
5. Sound Alternatives Report -
6. QHR Report – Quorum Monthly Updates **Pgs. 36-52**

G. CORRESPONDENCE

H. ACTION ITEMS

*Executive Session: Subjects that may be considered in executive session are: 1) Matters, immediate knowledge of which would clearly have an adverse effect upon the finances of the public entity; 2) Subjects that tend to prejudice the reputation and character of any person, provided that the person may request a public discussion; 3) Matters which by law, municipal charter, or ordinance are required to be confidential; 4) Matters involving consideration of governmental records that by law are not subject to public disclosure; 5) Direction to an attorney or labor negotiator regarding the handling of specific legal matters or labor negotiations.

I. DISCUSSION ITEMS

J. AUDIENCE PARTICIPATION (limited to 3 minutes per speaker)

Members of the public are given the opportunity to comment on matters which are within the subject matter jurisdiction of the Board and are appropriate for discussion in an open session.

K. BOARD MEMBERS COMMENTS

L. EXECUTIVE SESSION

1. Discuss External Contracts
2. Meaningful Use Reimbursements
3. CEO Candidates

M. ADJOURNMENT

*Executive Session: Subjects that may be considered in executive session are: 1) Matters, immediate knowledge of which would clearly have an adverse effect upon the finances of the public entity; 2) Subjects that tend to prejudice the reputation and character of any person, provided that the person may request a public discussion; 3) Matters which by law, municipal charter, or ordinance are required to be confidential; 4) Matters involving consideration of governmental records that by law are not subject to public disclosure; 5) Direction to an attorney or labor negotiator regarding the handling of specific legal matters or labor negotiations.

SUBJECT: INTRAVENOUS CONTRAST ADMINISTRATION	RAD P018	
DEPARTMENT: X-ray	☒ New	**Date:**
POLICY OWNER: Radiology	☐ Revised	
Original Approval Date: (written out)	☐ Reviewed	12/28/2015
Approved by: Name/Signature (signature only for master)		Page 1 of 14

Policy

SUBJECT/TITLE: INTRAVENOUS CONTRAST ADMINISTRATION

PURPOSE:

1) Ensure appropriate premedication in patients with known/suspected allergic reactions;

2) Ensure contrast administration is performed according to hospital and departmental protocols with appropriate supervision by a licensed independent practitioner (LIP).
3) Ensure appropriate actions are undertaken in case of contrast reactions and extravasation of contrast.
4) Ensure laboratory testing requirements conducted in patients in whom contrast administration is considered.

DEFINITION: None

CONTENTS:

SUBJECT: INTRAVENOUS CONTRAST ADMINISTRATION	RAD P018	
DEPARTMENT: X-ray	☒ New	**Date:**
POLICY OWNER: Radiology	☐ Revised	
Original Approval Date: (written out)	☐ Reviewed	12/28/2015
Approved by: Name/Signature (signature only for master)		Page 2 of 14

POLICY:

Guidelines for administration of intravenous contrast:

1. A radiologic technologist or RN may administer intravenous contrast under the supervision of a licensed independent practitioner (LIP) and in accordance with procedure defined in this policy and following protocols used for contrast administration that are based upon the type of examination ordered and define the type, dose and route of contrast.
2. If an exam is ordered by a provider that does not meet routine protocols the technologist will notifiy the medical director to speak with ordering provider before exam is done. A examples of this is a study is ordered with contrast that does not require contrast, an exam ordered without contrast that requires contrast, or any other changes in routine protocols in any way.
3. The supervising LIP or his/her physician designee must be available to respond promptly to an adverse event related to contrast administration.
4. Protocols for administration of intravenous contrast must be reviewed by QMC when the standards of care and application change or when the characteristics of the intravenous contrast change.
5. A radiologic technologist or RN will review patient's current medications and clinical conditions for contraindications related to intravenous contrast administration. These include allergy to contrast, use of particular medications (e.g., metformin – see below), and general physical condition which may impact risks for patient, such as heart failure and asthma.
6. If contraindications are identified, the supervising LIP will be contacted to determine appropriate IV contrast use.
7. Type of contrast and dose information is recorded in the EMR by the nurse or technologist.
8. Contrast doses that are prepared and NOT immediately administered to patient by the person who prepared the dose must be labeled with:
    - Drug name, strength and amount (if not apparent from container)
    - Initials or name of the person preparing the syringe
    - Name of patient, medical record number, date of birth and location of the patient, if contrast dose is prepared based upon specific patient information.
    - The dose should be used immediately and not stored.

SUBJECT: INTRAVENOUS CONTRAST ADMINISTRATION	RAD P018	
DEPARTMENT: X-ray	☒ New	**Date:**
POLICY OWNER: Radiology	☐ Revised	
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PROCEDURE:

A. INTRAVENOUS IODINATED CONTRAST

All intravenous contrast utilized for CT exams at CCMC utilize iodine. The differing contrast agents will vary based on the form that the iodine is organically bound. Other variables in the type of iodinated contrast include ionic vs. nonionic, high osmolar (HOCM) vs. low osmolar (LOCM), and iso-osmolar contrast media. All contrast injections will require a creditialed provider to be made aware of the study, and to be present at CCMC.

Preparation for Contrast Administration

1. Pre-administration Checks (4 Hs)

The ACR manual describes the 4 Hs

a. History
b. Hydration
c. Have equipment and expertise ready
d. Heads up

These checks have an effect on both the need for premedication, the risk of contrast extravasation, and the need for laboratory testing.

2. Renal failure-related issues with iodinated contrast

a. Iodinated contrast has been implicated in causing significant decreased renal function in some patients following its administration, an effect called contrast media nephrotoxicity.
b. Significant contrast media induced nephrotoxicity may be defined as:
   - a >25% rise in serum creatinine from baseline (if < 1.5 mg/dl)

   OR

   - an absolute elevation of >1.0 mg/dl from baseline (if > 1.5 mg/dl) within 72 hours following contrast administration.

3. Risk factors for contrast induced renal failure include:

a. Pre-existing renal insufficiency
b. History of "kidney disease" as an adult, including tumor and transplant
c. Diabetes mellitus
d. Dehydration

e. Cardiovascular disease and use of diuretics
f. Age > 60 years
g. Multiple myeloma or paraproteinemia syndromes/diseases
h. Uncontrolled Hypertension
i. Hyperuricemia (gout)

4. **Medications which may increase the risk of iodinated contrast-induced renal failure.**
   a. **Metformin** (oral hypoglycemic agent for diabetes): This drug is excreted by the kidneys, and may accumulate resulting in severe (even fatal) lactic acidosis.
   b. **NSAIDs including COX-2 selective agents** (e.g., ibuprofen, naproxen, ketorolac, fenoprofen, indomethacin, celecoxib, etc.)
   c. **Nephrotoxic antimicrobials** (e.g., gentamicin, tobramycin, amikacin, amphotericin B, cidofovir)

5. Indications for serum creatinine prior to iodinated contrast exam

The following patients must have a serum creatinine within 60 days prior to the exam:

Age > 60
History of renal disease, including: • Dialysis • Kidney transplant • Single kidney • Renal cancer • Renal surgery
History of hypertension requiring medical therapy
History of diabetes mellitus
Metformin or metformin-containing drug combinations

6. Measures to Prevention/Ameliorate Nephrotoxicity

a. Hydration if required. Normally, this can be achieved by oral administration of 1-2 liters of extra fluids in the 24 hours prior to contrast injection. In some cases, this can be achieved using 0.45% or 0.9% saline, 100 ml/hr from 12 hours before until 12 hours after contrast administration.

b. Withhold furosemide.
c. Withhold metformin for 48 hours after contrast administration and reinstitute only after repeat renal function tests (creatinine) had been obtained and determined to be normal.
d. In patients with risk factors for contrast-induced renal failure, administer acetylcysteine, 600 mg by mouth twice daily on the day before and on the day of contrast administration (4 total doses).

7. Patients on Dialysis

Patients on dialysis can receive IV contrast, and early post-procedural dialysis is NOT routinely required in every case. The Nephrology Service should be consulted for these cases. The fact that a patient is on dialysis should NOT be regarded as automatically allowing the administration IV contrast.

CONTRAST REACTIONS TO IODINATED IV CONTRAST

Reactions to iodinated IV contrast occur in 1-3% of nonionic low-osmolar contrast injections. These range from mild urticaria (hives) to severe and life-threatening events. The severe lifethreatening reactions are relatively rare. Although overall adverse reactions are decreased following steroid premedication, the incidence of severe life-threatening adverse events has not been affected. Therefore, administration of IV contrast in patients with previous severe reactions should be done only in exceptional circumstances with full agreement by the patient, attending physician(s).

1. Premedication

The following regimens are suggested based on the ACR Manual on Contrast media version 8. 2012:

a. **Planned** contrast administration in patients with previous documented/suspected reaction: Two frequently used regimens are:
1. Prednisone 50 mg by mouth at 13 hours, 7 hours, and 1 hour before contrast media injection, plus diphenhydramine (Benadryl®) 50 mg intravenously, intramuscularly, or by mouth 1 hour before contrast medium. or
2. Methylprednisolone (Medrol®) 32 mg by mouth 12 hours and 2 hours before contrast media injection. An antihistamine (as in option 1) can also be added to this regimen injection. If the patient is unable to take oral medication, 200 mg of hydrocortisone intravenously may be substituted for oral prednisone.

b. **(Semi-) acute** investigations in patients with previous documented/suspected reaction: The ordering physicians are encouraged to discuss the indication for contrast administration with the radiologist for alternative imaging.

In decreasing order of desirability:

1. Methylprednisolone sodium succinate (Solu-Medrol®) 40 mg or hydrocortisone sodium succinate (Solu-Cortef®) 200 mg intravenously every 4 hours (q4h) until contrast study required plus diphenhydramine 50 mg IV 1 hour prior to contrast injection.
2. Dexamethasone sodium phosphate (Decadron®) 7.5 mg or betamethasone 6 mg intramuscularly q4h until contrast study must be done in patent with known allergy to methylprednisolone, aspirin, or non-steroidal antiinflammatory drugs, especially if asthmatic. Also diphenhydramine 50 mg IV 1 hour prior to contrast injection.
3. Omit steroids entirely and give diphenhydramine 50 mg IV.

Note: IV steroids have been shown to be less effective when administered less than 4 to 6 hours prior to contrast injection.

c. **Pediatric pre-medication**

Prednisone 0.5-0.7 mg/kg PO (up to 50 mg) 13 hours, 7 hours, and 1 hour prior to contrast administration

AND

Diphenhydramine (Benadryl®) 1.25 mg/kg PO (up to 50 mg) 1 hour prior to contrast administration

d. **Use of these pre-medication regimens may result in impairments that affect the patient's ability to drive. Appropriate precautions are advised i.e., designated driver.**

e. The ***non-emergent*** patients with contrast allergy, severe enough to require premedication may not be scanned after hours. The pre medication may be scheduled in such a way that the patient is scanned the first thing next morning, when we have full manpower to handle any breakthrough reactions.

f. If clinical situation warrants emergent scanning after hours in a patient who has received either the premedication for prior contrast allergy:

- The afterhours scanning of the premedicated patient should be approved by the on call provider.
- The technologist will page the on-call provider before administering the contrast.

g. On call and on weekends, any case with contrast allergy should go through the on-call provider to determine if the study needs to be done after hours or to suggest alternative method of scanning vs. premedication.

2. **Emergent contrast administration in life-threatening situations**

Consider a medical evac transfer to a facility better equipped for dealing with these situations. In cases of life-threatening emergency requiring administration of IV contrast and where the ordering provider cannot wait for the premedication by the **acute/semi-acute** protocol requiring administration of steroids 4 hours and 1 hour prior to the procedure and the alternative test is not acceptable:

a. The ordering physician must add a note in the **medical record** of the patient prior to the contrast administration which clearly states the following:
   - Indication of the urgent study.
   - Reason why the alternative exam, if one is available is not acceptable.
   - Ensure that sufficient staff capable of handling the severe contrast reaction; including intubation and administration of life support drugs will be available during and after the procedure.

b. You may consider giving hydrocortisone 200 mg IV AND diphenhydramine (Benadryl®) 50 mg IV stat prior to contrast administration and 4 hours later to cover delayed reaction, although according to the ACR manual *"IV steroids have not been shown to be effective when administered less than 4 to 6 hours prior to contrast injection."*

B. NON-INTRAVENOUS CONTRAST AGENTS

1. Oral contrast agents such as MD-Gastroview®, Gastrografin® are medications and preparation and administration should be done as directed.

2. All procedures requiring the administration of oral contrast agents must have a written order.

3. Protocols for administration and preparation of oral contrast must be reviewed by QMC when the standards of care and application change or when the characteristics of the oral contrast agent change.

4. Orders for contrast administration are reviewed by technologist to determine appropriateness. The currently used oral contrast preparations for CT procedures have minimal adverse effects.

5. Oral contrast that are for in-patients/ ER must include the following information on the prep form:

    a. Drug name and amount used
    b. Time and date the contrast was prepared and initials of the person who prepared the container.
    c. Name of patient, medical record number, date of birth, and location of the patient.
    d. Directions and administration times in relation to Radiology procedure.

C. PEDIATRIC IV CONTRAST ADMINISTRATION

1. For iodinated contrast media agents, the same principles apply in adults as in children. The dose of contrast is delivered based on weight of the patient (2 ml/kg).

    References for pediatric contrast media use:

    a. http://www.acr.org/~/media/ACR/Documents/PDF/QualitySafety/Resources/Contrast%20Manual/Contrast%20Media%20in%20Children.pdf

    b. http://bjr.birjournals.org/cgi/reprint/70/839/1104.pdf

    c. http://www.springerlink.com/content/3211318t384ug062/fulltext.pdf

    d. http://emedicine.medscape.com/article/422855-print

    e. http://radiology.rsna.org/content/243/1/80.full.pdf+html

D. TREATMENT OF CONTRAST MEDIA REACTION

In all cases, treatment should begin with:

- IV access and monitor frequent vitals
- Maintain the ABCs (airway, breathing, circulation)
- Call Code for severe reactions
- Document allergy in EMR

Table 1: Suggested Treatments for Adults w/ Adverse Effects to Contrast Agents

Hives		
Mild (Scattered & transient)	None	Observe until resolving
Moderate (numerous & bothersome to the patient)	Diphenhydramine (Benadryl®) OR Fexofenadine	25-50 mg oral (causes drowsiness; patient will need a designated driver) 180 mg po (for patients without a driver)
Severe (profound)	Secure IV access	50 mg IV Diphenhydramine (Benadryl®)
Diffuse erythema		
Mild	Secure IV access, IV fluids	0.9% NaCl or Lactated Ringer's 1-2 liters IV
	Consider: diphenhydramine	50 mg oral or IV
	Consider: hydrocortisone	200 mg IV
Severe	Epinephrine	0.3 mg /0.3 ml IM (1:1,000), if inadequate response; 0.1 mg/1 ml (1:10,000) slow IV; repeat as needed up to 1 mg/10 ml total dose
	CALL CODE	

Laryngeal edema		
Bronchospasm	Secure IV access, O_2 by mask	10 l/min O_2
	Epinephrine	0.1 mg/1 ml (1:10,000) slow IV; repeat as needed up to 1 mg/10 ml total dose
	CALL CODE	
	Hydrocortisone	200 mg IV, repeat if necessary
Mild		
Mild Moderate	Albuterol inhaler	2 puffs, repeat as necessary
	Secure IV access, O_2 by mask	10 l/min O_2
Severe	Epinephrine IM*	0.3 mg/0.3 ml (1:1,000) IM; may repeat once
Severe **Table 1 (cont): Suggested Treatments for Adults w/ Adverse Effects to Contrast Agents**	Epinephrine IV	0.1 mg/1 ml (1:10,000) slow IV; repeat as needed up to 1 mg/10 ml total dose
	CALL CODE	
Pulmonary Edema		
Hypotension with Bradycardia	Secure IV access O_2 by mask	10 l/min O_2
	Elevate head of bed	
	Furosemide	20-40 mg IV, slowly (≥10 mg/minute)
	Morphine	1-3 mg IV, repeat every 5-10 min as needed
	CALL CODE	
Mild		
Mild Severe	Elevate legs	
	Secure IV access, IV fluids	0.9% NaCl or Lactated Ringer's 1-2 liters
	O_2 by mask	10 l/min O_2
Hypotension with Tachycardia	Atropine	0.6 mg – 1 mg IV, slow; up to 2-3 mg total dose (0.04 mg/kg)
Mild		
Mild	Elevate legs	

Severe	Secure IV access	
	IV fluids	0.9% NaCl or Lactated Ringer's 1-2 liters
	O_2 by mask	10 l/min O_2
Severe **Hypertension Crisis (diastolic BP > 120 mmHg)**	Epinephrine	0.1 mg/1 ml (1:10,000) slow IV; repeat as needed up to 1 mg (10 ml total dose)
	CALL RAPID RESPONSE	

Hypoglycemia (blood sugar below 50-60)	Secure IV access	
	O_2 by mask	10 l/min O_2
	Labetalol (first choice)	20mg IV over 2 minutes, may repeat q 10 minutes
	Furosemide (if labetalol is not available)	40 mg IV slowly (over at least 4 minutes)
	Nitroglycerin	0.4 mg sublingual; repeat after 5-10 min x 3
	CALL RAPID RESPONSE	

If patient is able to swallow safely

If patient is able to swallow safely If patient is unable to swallow safely	Secure IV access	
	O_2 by mask	6-10 L/min O_2
	Administer oral glucose	15 grams of glucose tablet/gel or ½ cup (4 oz) of fruit juice
If patient is unable to swallow safely * In hypotensive patients, the preferred route of epinephrine delivery is IV as the extremities may not be perfused sufficiently to allow adequate absorption of IM administration	If IV access present, administer Dextrose 50% IV	D50W IV 1 ampule (25 grams) IV push over 2 minutes (rate 100 mL/hr)
	If IV access not present, administer Glucagon	1 mg (1 mg/mL) IM/SQ Following Glucagon treatment provide a snack

E. TREATMENT AND PREVENTION OF CONTRAST EXTRAVASATION

Methods to Decrease the Risk of Extravasation during Injection of Contrast Media

1. Most CT protocols use power injectors. There is preference for 20-gauge or larger catheters/cannulas with flow rates of 3 ml/second or higher.
2. Patients should be instructed about potential extravasation and how to alert the tech. All injections should be monitored during the first 8-10 seconds of injection to ensure no extravasation occurs early. Communication with the patient should continue via intercom during injection.
3. Use of standard central venous catheters should be discouraged, but Power PICC lines (purple) and Power Ports may be used for contrast injection should the situation demand it.
4. Extravasation of any contrast volume should be treated in accordance with the following paragraphs.
5. Risk factors that have been identified for contrast extravasation include:
    a. Inadequate communication (elderly, altered consciousness)
    b. Severely ill/debilitated patients
    c. Patients with abnormal circulation to limb to be injected (atherosclerosis, Raynaud's disease, venous thrombosis/insufficiency, prior radiation therapy, previous [axillary] surgery)
    d. More peripheral injection sites (hand, wrist, foot, ankle)
    e. Injection through line that has been present >24 hrs

Treatment of Extravasation of IV Contrast Media

1. **Observation** is required if extravasation <100 ml low osmolar contrast media: a. Notify provider.
    b. Elevate affected limb above the heart. Check the pulses and sensations.
    c. No clear evidence favoring the use of warm or cold packs (ACR manual 2010). Suggested applying cold pack for immediate relief of pain and burning x 30 minutes followed by warm pack x 12-24 hours to facilitate absorption of the contrast.
    d. If >5 ml extravasated: observation for 2-4 hours.
    e. The radiologist may at his/her discretion discharge a patient less than 2-4 hours with gadolinium agent extravasation. The guidelines for IV contrast media extravasation may be referred to as needed.

f. Watch for increasing pain, swelling, blisters, numbness or tingling.
g. Disposition to be determined by the radiologist or the LIP.
h. Record the event and the treatment in the patients chart.

2. **Surgical (plastic surgery) consultation** is required in the following situations:
   a. Extravasation >100 ml low-osmolar contrast media.
   b. Increased swelling or pain after 2-4 hours.
   c. Altered tissue perfusion.
   d. Change in sensation or temperature.
   e. Development of skin ulceration or blistering.

F. PREGNANCY AND BREAST FEEDING

Pregnancy

1. During pregnancy, it is safe practice to limit ionizing radiation as much as possible. Nevertheless, the risk of missing a diagnosis or mismanagement in the absence of a significant diagnosis will take precedent over any risks to the mother and fetus.
2. The administration of iodinated contrast and oral contrast agents has no known risks during any trimester.
   a. The decision to use intravenous contrast must be made on a case-by case basis by the LIP, who will confer with the referring physician to assess the risk– benefit tradeoffs for that patient. The medical necessity to use contrast during pregnancy must be documented in the patient's medical record by the attending physician who requested the study must be in the patient's medical record before procedure can be performed.
   b. If it is determined that contrast is needed, the patient or legal guardian must sign a procedural consent form.

Breast Feeding

The literature on the excretion into breast milk of iodinated and gadolinium-based contrast media and the gastrointestinal absorption of these agents from breast milk is very limited; however, several studies have shown that 1) less than 1% of the administered maternal dose of contrast medium is excreted into breast milk; and 2) less than 1% of the contrast medium in breast milk ingested by an infant is absorbed

from the gastrointestinal tract. Therefore, the expected dose of contrast medium absorbed by an infant from ingested breast milk is extremely low.

1. ***Iodinated contrast agents*** are excreted rapidly through the kidneys, and less than 1% is excreted into breast milk during the first 24 hours. Therefore, it is considered safe for the mother to continue breast feeding after receiving iodinated contrast.
2. If the patient has any question or concerns they can speak to the LIP.
3. If the patient still has concerns they can pump and throw their milk away for the next 24 hours after their injection.

Administrator Signature		**Date**	1/29/16
Dept. Mgr/Committee Chair Signature	Kenneth K Byrd	**Date**	1/29/16
Review Signature		**Date**	
Review Signature		**Date**	
Review Signature		**Date**	
Review Signature		**Date**	
Review Signature		**Date**	

Cordova Community Medical Center
Policy

SUBJECT: Exercise Guidelines	RS P102
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 1

Policy:

Exercise guidelines will be followed by staff therapists.

Procedures:

1. Assigned therapists will establish and make changes to the patient's exercise program.

2. The exercise program will be documented in the patient's medical record.

3. The documented exercise program will include:
   a. The number of reps/sets performed by the patient.
   b. Any necessary verbal/tactile instructions/cues provided by the therapist to the patient.
   c. The specific weight/resistance used during the exercise.
   d. The specific type of equipment being used during the exercise.
   e. Any subjective or objective adverse reactions of the patient during or immediately following the performance of the exercise.
   f. The specific joint/region of the body being exercised and the direction of movement, unless the exercise is intended to specifically target heart rate, aerobic conditioning, etc.

4. The therapist will set up and /or assist the patient in setting up exercise equipment as needed.

Administrator Signature _____	Date 10/15/15
Dept. Mgr/Committee Chair Signature _____	Date 10/14/15
Review Signature _____	Date _____
Review Signature _____	Date _____
Review Signature _____	Date _____
Review Signature _____	Date _____
Review Signature _____	Date _____

Cordova Community Medical Center
Policy

SUBJECT: Safe Lifting	RS P103
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 1

Policy:

The staff therapist will instruct patients on safe lifting practices as necessary. Rehabilitation Services will instruct staff on safe lifting practices in the work place as requested by department heads.

Procedures:

A safe lift is composed of the following components:

1. Maintenance of a neutral spine position of a natural lumbar lordosis.
2. Contraction of the abdominal muscles.
3. Flexion at the hips and knees.
4. Pre-assessment of the weight of the load.
5. Avoidance of trunk twisting.
6. Lifting load as close to center of gravity as possible.
7. Separation of the feet in a broad based, stable stance.
8. Pivots with the feet.

Administrator Signature _____ Date 10/18/15
Dept. Mgr/Committee Chair Signature _____ Date 10/14/15

Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____

Cordova Community Medical Center
Policy

SUBJECT: Electrical Stimulation	RS P105
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 1

Policy:

Guidelines for the use of electrical stimulation will be followed by the staff therapists.

Procedures:

1. Prior to treatment the patient will be informed of the indications/benefits of electrical stimulation in regards to the patient's diagnosis and what the patient is to expect during the course of the treatment.

2. The therapist using the electrical stimulation machine will refer to the instruction manual as needed before using this equipment.

3. The instruction manual will be kept in the "Product and Equipment Information" section in the Rehab Services Department or may be found online.

4. Indications for electrical stimulation may include but are not limited to: muscle spasm, muscle/joint pain, joint effusion, and muscle weakness.

5. Contraindications, warnings, and precautions regarding the use of electrical stimulation are found in the instruction manual but are not limited to that list.

Administrator Signature		Date 10/15/15
Dept. Mgr/Committee Chair Signature		Date 10/14/15
Review Signature		Date
Review Signature		Date
Review Signature		Date
Review Signature		Date
Review Signature		Date

Cordova Community Medical Center
Policy

SUBJECT: Gait Belt for Tansfers	RS P106
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 2

Policy:

Gait belts are provided to assist staff to safely transfer and ambulate residents where indicated. Gait belts are not to be used as a restraint.

Procedures:

1. Explain the procedure to the resident/patient.

2. Apply the belt around the resident's/patient's waist.
   a. Pass the metal-tipped end through the buckle under the teeth.
   b. Bring the tip of the belt across the front of the buckle and slip it through to the other side.
   c. Ensure the belt is snug but allows enough room for your hand to comfortably grasp it.

3. Stand as close to the resident/patient as possible, maintaining a broad base of support.

4. To transfer:
   a. From in front of the resident/patient, assist him/her to a standing position by grasping the belt at the sides of the waist from underneath the arms.
   b. Pivot the resident/patient into a chair or to the bed.

5. To ambulate:
   a. Assist the resident/patient to a standing position by grasping the belt at the waist from the back.
   b. Standing on the resident's/patient's weaker side and to the rear, wrap your arm around the waist of the resident/patient and grasp the belt from behind.
   c. Maintain a firm grasp on the belt and proceed with ambulation following any weight bearing restrictions indicated.

6. When the transfer is completed, remove the belt and return it to the storage or the resident's/patient's room.

7. When two people are available to assist in transferring a resident/patient, the same procedures apply.

Cordova Community Medical Center
Policy

SUBJECT: Gait Belt for Tansfers	RS P106
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 2 of 2

Administrator Signature _____ Date 10/15/15
Dept. Mgr/Committee Chair Signature _____ Date 10/14/15

Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____

Cordova Community Medical Center
Policy

SUBJECT: Transcutaneous Electrical Nerve Stimulation (TENS) Unit	RS P201
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 1

Policy:

TENS units are used for pain control.

Procedures:

1. The use of a TENS unit requires a Medical Provider's order or must be defined in the Plan of Care by the assigned therapist.

2. The TENS electrodes will be billed as they are supplied to the patient.

3. When a TENS unit is ordered:
   a. Monitor the unit daily for inpatient use.
   b. For outpatient use monitor the unit at each visit to assure that the settings are effective and that the unit is working correctly.
   c. Record the visit in the patient's medical record.

4. After a patient is discharged from therapy:
   a. Discard that patients designated electrodes.
   b. Return unit to vendor per vendor's instructions.

Cross – Reference:

RS P202 Operation of Rehabilitation Services Department Equipment

Administrator Signature	Date 10/15/15
Dept. Mgr/Committee Chair Signature	Date 10/14/15
Review Signature	Date
Review Signature	Date
Review Signature	Date
Review Signature	Date
Review Signature	Date

Cordova Community Medical Center
Policy

SUBJECT: Operation of Rehabilitation Services Equipment	RS P202
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 2

Policy:

All equipment in Rehabilitation Services is operated in accordance with the guidelines outlined in the equipment manuals.

Procedures:

1. The equipment manuals located in the "Equipment Manual" section of the Rehab Services department or online and will be referred to before using the equipment, if questions arise.

2. The following equipment will only be utilized under the supervision of the Rehab Services personnel:
   a. Hydroculator
   b. Hot Packs
   c. Cold Packs
   d. Total gym
   e. Parallel bars
   f. Stationary bike
   g. Weights
   h. Stairs
   i. Treadmill
   j. Electrical Stimulation
   k. Ultrasound
   l. Iontophoresis
   m. Transcutaneus Electrical Nerve Stimulator (TENS)
   n. Over the door cervical traction unit

3. The following equipment may be utilized without supervision of Rehab services personnel on a case by case basis:
   a. NUSTEP

SUBJECT: Operation of Rehabilitation Services Equipment	RS P202
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 2 of 2

Cross – Reference:

RS P201 Transcutaneous Electrical Nerve Stimulation (TENS) Unit

Administrator Signature _____ Date 10/15/15

Dept. Mgr/Committee Chair Signature _____ Date 10/14/15

Review Signature _____ Date _____

Review Signature _____ Date _____

Review Signature _____ Date _____

Review Signature _____ Date _____

Review Signature _____ Date _____

Cordova Community Medical Center
Policy

SUBJECT: Hydrocollator Cleaning	RS P203
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 2

Policy:

Filling and emptying of the hydrocollator unit will be done based on frequency of use. When in use, the hydrocollator will be cleaned every two weeks.

Procedures:

1. Return the hydrocollator to the treatment preparation area.
2. Log the appropriate information on the designated checklist form located next to the hydrocollator.
3. It will take approximately 4 hours for the hydrocollator to return to the required temperature.
4. Replace the hot packs in the hydrocollator once the temperature has reached the required temperature.

To clean and empty the hydrocollator:

1. Unplug the unit.
2. Remove the hot packs.
3. Drain the water from the tank and carefully discard the hot water in a floor drain in the utility closet.
4. Allow the tank to cool before touching the inside surface.
5. Scrub the inside with hospital approved disinfectant.
6. Rinse well to remove chemicals.

Cordova Community Medical Center
Policy

SUBJECT: Hydrocollator Cleaning	RS P203
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 2 of 2

Attachment:

RS P203a Hydrocollator Cleaning & Temperature Log

Administrator Signature _____ Date 10/16/15

Dept. Mgr/Committee Chair Signature _____ Date 10/14/15

Review Signature _____ Date _____

Review Signature _____ Date _____

Review Signature _____ Date _____

Review Signature _____ Date _____

Review Signature _____ Date _____

Cordova Community Medical Center
Hydrocollator Cleaning and Temperature Log

Recommended Temperature Between 160°F - 166°F

Date	Temperature	Cleaned	Staff Initials	Comments

Cordova Community Medical Center
Policy

SUBJECT: Temperature Checks of the Hydrocollator	RS P204
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 1

Policy:

The Hydrocollator will be unplugged and drained of water and hot packs until needed.

Procedures:

1. Place a high-temperature thermometer in the Hydrocollator.

2. Log the appropriate information on the Hydrocollator Cleaning and Temperature log which will be located next to the Hydrocollator.

3. The hydrocollator temperature will be maintained between 160F – 166F. If the temperature can not be adjusted to withing the recommended range, do not use the hot packs and contact the maintenance department.

4. If needed for extended period of time, the temperature will be checked on a weekly basis.

Cross - Reference:

RS P203a Hydrocollator Cleaning & Temperature Log

Administrator Signature _____ Date 10/15/15
Dept. Mgr/Committee Chair Signature _____ Date 10/14/15

Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____

Cordova Community Medical Center
Policy

SUBJECT: Ultrasound	RS P206
DEPARTMENT: Rehabilitation Services	☐ New **Date:**
POLICY OWNER: Director of Rehabilitation Services	☒ Revised 9/29/2015
Original Approval Date: October 6, 2008	☐ Reviewed
Approved by: Randy Apodaca	Page 1 of 1

Policy:

Guidelines for the use of ultrasound will be followed by staff therapists.

Procedures:

1. Prior to treatment the patient will be informed of the benefits of ultrasound, the purpose of ultrasound regarding the patient's diagnosis and what the patient is to expect during the course of treatment.

2. The treating therapist will refer to the Instruction Manual as needed when utilizing the ultrasound machine.

3. The instruction manual will be kept in the "Product and Equipment Information" section of the RS department and may also be found online.

4. Indications, precautions, and contraindications regarding the use of ultrasound are found in the instruction manual, but are not necessarily exclusive to that list.

Administrator Signature _____ Date 10/15/15
Dept. Mgr/Committee Chair Signature _____ Date 10/14/15

Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____
Review Signature _____ Date _____

Minutes
Community Health Services Board
Cordova Center – Community Rooms A & B
March 10, 2016 at 12:15pm
Regular Meeting

I. CALL TO ORDER AND ROLL CALL –

Kristin Carpenter called the HSB special meeting to order at 12:16pm. Board members present: **Kristin Carpenter, Tim Joyce** (telephonically)**, Tom Bailer** (telephonically)**, James Burton.**
A quorum was established.
CCMC staff present: Noel Rea, Interim CEO; Kim Wilson, HR Coordinator; Olinda White, Interim CFO and Stephen Sundby, Sound Alternatives Executive Director.

II. APPROVAL OF AGENDA
M/Burton S/Joyce "move to approve the agenda."

M/Burton S/ Joyce "modify agenda to read Reports of Officers and Advisors to include QHR as #6 as a standing item."
Vote on motion: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

III. CONFLICT OF INTEREST ~ None

IV. COMMUNICATIONS BY AND PETITIONS FROM VISITORS
- **Guest Speakers ~** None
- **Audience Comments ~** None

V. APPROVAL OF CONSENT CALENDAR
FS 908 – Capitalization
No objection to approve the Consent Calendar
Vote on motion: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

VI. APPROVAL OF MINUTES
M/Bailer S/Joyce "move to approve the minutes from the February 11, 2016, HSB Regular Meeting."
Vote on motion: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

VII. REPORTS OF OFFICERS
President's Report ~ Carpenter reported that she had met with Noel last week about the Agenda and Executive Session. Carpenter had also been in touch with Ron Vigus with QHR regarding the CEO candidates. The dates have been set for March 21-22 for CEO interviews, Ron has offered to come to Cordova and sit in on the interviews if the board so chooses.

The Board came to an agreement that it was not necessary for Ron Vigus to fly to Cordova for the interviews, that all of the upcoming CEO interviews will be done either telephonically or via Skype and that Ron Vigus is invited to be present via the same method.

Administrator's Report ~ Noel Rea reported that Kim Wilson had been doing a great job putting together the facility wide Sexual Harassment Training. We are looking at a savings of approximately $80k over the next year using Amerinet Group Purchasing, and that is not

including savings from all departments in the facility. Revenue is up in February. In approximately 4 – 6 weeks we should be receiving Meaningful Use money. We will be hosting a community gathering welcoming Dr. Sanders. And I am hoping to have Joe Tye, author of The Florence Prescription come to Cordova the end of April.

Finance Report ~

Medical Director's Report ~ None

VIII. CORRESPONDENCE

1. QView February 2016
2. February 2016 – QHR Board Minutes
3. IVantage 2016 Methodology
4. IVantage 2016 Rural Relevance Study

IX. ACTION ITEMS

1. Resolution to update CCMC Authorized Check Signers

M/Burton S/Joyce "I move to approve the Resolution of the Cordova Health Services Board designating the representatives authorized for signing checks, non-check payroll tax payment, and cash transfers for Cordova Community Medical Center."

M/Burton S/Joyce "Amend the resolution to add HSB Vice-President Tim Joyce as an authorized check signer for CCMC."
Vote on amendment: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

M/Carpenter S/Burton "Amend the resolution to strike Randy Apodaca from the names to remove as an authorized check signer for CCMC."
Vote on second amendment: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

Vote on main motion: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

2. Resolution of Lease-Purchase Equipment Agreement

M/Burton S/Bailer "move to approve the Resolution of the Cordova Health Services Board approving the Equipment Lease-Purchase Agreement for the CT scanner."

M/Burton S/Joyce "I move to refer back to staff"
Vote on motion: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

X. DISCUSSION ITEMS ~ None

XI. AUDIENCE PARTICIPATION ~ None

XII. BOARD MEMBERS COMMENTS

Joyce – I agree with James, it would be nice to have the folks that are there helping to decide how they wanted to do it too.
Hallquist – Absent
Burton - My thought on the interviews for CEO, If this board is going to change between now and the CEO Interviews, would we like to hear from the new City Council members as they will also be the ones that will have to work with this individual for the next 3 years?
Bailer – I would agree with that. And I appreciate James Burton bringing that up in such a manner so that they (new Council Members) that opportunity.
Reggiani – Absent
Beedle – Absent
Carpenter – I had thought that Susan was going to swear people in after this meeting. Which would mean that you would be participating because at that point you would be the Council.

M/Burton S/Bailer "I move to suspend Roberts Rules for the remainder of the meeting to include the new City Council members in the discussion"
Vote on motion: 4 yeas, 0 nays, 3 absent. Carpenter-yes; Joyce-yes; Bailer-yes; and Burton-yes. Beedle-absent; Reggiani-absent and Hallquist-absent. Motion was approved.

Wiese – With Skype being out there I think that its' something that we should get used to, honing our skills as a board that will need to learn how to read people like this. It's obviously going to save us a lot of money on airfare, flying people back and forth is expensive. It's out there and I think we should be putting our best foot forward in using it. I did have a comment on something that Kristin had said about someone needing to get a feel for Cordova, there is a lot of merit to that. What good does it do to hire someone who can't live here?
Allison - I ditto that, I think the phone is good for the first round of interviews. Other than Noel, if there is someone that we're interested in taking a closer look at, we can fly them up later. It does no good bringing them up on a day like today (blue skies and sunny) and they'll love it, until we have two weeks straight of rain then they might have a different attitude.

XIII. Executive Session

At 1:15pm M/Burton S/Joyce "move to go into executive session for matters, immediate knowledge of which would clearly have an adverse effect upon the finances of CCMC."

Interim CEO Noel Rea, Interim CFO Olinda White, James Wiese and David Allison were invited to join the Executive Session.

HSB Members came out of Executive Session at 2:11pm

XIX. ADJOURNMENT –
M/Burton S/Joyce "I Move to adjourn the meeting."
Carpenter declared the meeting adjourned at 2:13pm.

Prepared by: Faith Wheeler-Jeppson

Cordova Community
MEDICAL CENTER
P: (907) 424-8000 | F: (907) 424-8116
P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

Date: April 11th, 2016
To: Health Services Board
From: Noel D. Rea, MBA, NHA, CCMC Interim CEO
RE: CEO Report

---

1. **Budget/Finance**

   - February Financial Statement is attached. The Statement compares this year to budget. Gross revenue was slightly over budget for the month, but cumulative is down by 6.13%. There was an increase in revenue on the budget of 5% that has not been implemented because we were waiting for the QRate study. Expenses are over budget by 5.92% due primarily to how we are recording USAC (Universal Services Funding) funding we get for our internet lines.

   - We need to raise charges as of May 1st. Raising charges 5% would add approximately $129,267, 7% would add approximately $180,992 and 10% would add $258,555. The staff recommendation is 7% so that it will come out to approximately 5% for the year and we have been told CCMC has been increasing over the last couple of years.

   - The month of March gross revenue is estimated to be down approximately 3.66% from March or down $28,158.02.

   - We will have statistical spreadsheets at the Board meeting comparing current and prior years.

2. **Recruitment**

   - Recruitment – We have had limited success getting potential applicants from the current recruiting agency. Staff is putting together a recruiting plan which will accommodate all critical open positions at CCMC. We will then develop a budget to share with the HSB to implement that plan.

3. **Staffing**

   - New Hires
     1. Physician (Start date of March 31, 2016)
     2. Interim Director of Nursing (start date March 9, 2016)
     3.

- Current Open Position
  1. CEO
  2. CFO
  3. Director of Nursing
  4. Long Term Care Coordinator
  5. 4 Registered Nurses
  6. 1 Physical Therapist
  7. 1 Medical Technologist
  8. 1 Quality Assurance/Performance Improvement RN (new)
  9. 1 Business Office Assistant (new) – on hold

- Current Travelers
  1. Interim Director of Nursing
  2. Interim Long Term Care Coordinator (RN)
  3. Interim CFO
  4. Interim CEO
  5. 4 Registered Nurses
  6. 3 LPN's
  7. 1 Physical Therapist
  8. 1 Medical Technologist

5. CFO Recruitment

- We have not received any applicants via Quorum in the last month. I have asked staff to explore opportunities where we can recruit directly from CCMC. We are more than adequately covered having Olinda White in place but would like to resolve this position in the near future.

6. CT Scanner

- Through 4.11.16 we have completed 24 CT exams resulting in total charges of $28,924. This should project out at roughly $175K for the year. Having a second physician now and the busy season coming I would anticipate we will see a larger total but will monitor this and report out regularly.

7. Board

- Thanks to the board member who have been able to meet. Your guidance is critical to keeping alignment between administration and the board. As a reminder we will have an evening conversation/session with Joe Tye on April 27th (location to be determined). Please take the time to read the book I shared as it will help make the time with Joe more meaningful. (FYI- we are also planning a session with the department heads of the city during Joe's time as well).

Cordova Community Medical Center
Cash Flow Statement
FYE 2016

	Jan-16	Feb-16
Cash in Bank - Operating		
Beginnng Balance	(3,031.90)	164,586.60
Deposits	717,308.30	715,658.75
Disbursements	549,689.80	818,278.87
Ending Balance	164,586.60	61,966.48
Cash In Bank - Payroll		
Beginning Balance	1,820.22	7,380.69
Deposits	172,000.00	335,000.00
Disbursements	166,439.53	340,906.16
Ending Balance	7,380.69	1,474.53
Cash in Bank - Sound Alternatives		
Beginning Balance	2,092.54	4,012.96
Deposits	1,920.42	99,698.80
Disbursements		100,000.00
Ending Balance	4,012.96	3,711.76
Cash in Bank - Money Market		
Beginning Balance	8.15	8.15
Deposits		2.77
Disbursements		
Ending Balance	8.15	10.92
Total Cash	175,988.40	67,163.69
Accounts Payable	936,747.58	949,880.32
Accounts Receivable		
Regular	1,273,736.08	1,139,663.54
Long Term Care	550,945.98	483,428.34
Total Receivables	1,824,682.06	1,623,091.88

Balance Sheet

10:57

Application Code : GL

User Login Name:lwhite

February 2016

Description	Year-To-Date Amount	Prior YTD Amount
ASSETS		
Cash & Cash Equivalents	188,010.61	274,526.26
Net Patient Receivables	917,796.29	742,076.65
Other Receivables	212,866.02	206,491.34
Fixed Assets	4,245,807.54	3,936,341.91
Prepaid Expenses	22,641.76	27,010.29
Inventory	148,482.43	152,281.27
TOTAL ASSETS	5,735,604.65	5,338,727.72
LIABILITIES		
Payables	3,321,152.89	2,190,564.53
Payroll Liabilities	589,943.07	493,855.01
Other Liabilities	161,029.92	75,439.41
TOTAL LIABILITIES	4,072,125.88	2,759,858.95
EQUITY/FUND BALANCE		
TOTAL FUND BALANCE	1,663,478.77	2,578,868.77
TOTAL LIABILITIES AND EQUITY	5,735,604.65	5,338,727.72

Profit & Loss Statement

10:56

Application Code : GL

User Login Name:lwhite

Through February 2016

Description	Period Amount	Budget Amount	Period Variance	Year-To-Date Amount	Year-to-date Budget	Year-To-Date Variance
REVENUE						
Acute	53,413.10	30,838.75	22,574.35	110,876.10	61,677.50	49,198.60
Swing Bed	92,825.37	92,045.17	780.20	110,452.37	184,090.34	-73,637.97
Long Term Care	339,516.87	346,378.16	-6,861.29	702,742.15	692,756.32	9,985.83
Clinic	86,707.87	63,293.00	23,414.87	139,543.13	126,586.00	12,957.13
Outpatients-Other	152,099.18	188,519.92	-36,420.74	294,694.32	377,039.84	-82,345.52
Behavioral Health	45,050.60	48,254.34	-3,203.74	86,160.38	96,508.68	-10,348.30
Patient Services Total	769,612.99	769,329.34	283.65	1,444,468.45	1,538,658.68	-94,190.23
DEDUCTIONS						
Charity	-616.42	21,803.59	-22,420.01	-616.42	43,607.18	-44,223.60
Contractual Adjustments	149,683.39	94,385.02	55,298.37	316,760.53	188,770.04	127,990.49
Bad Debt	73,707.13	18,575.58	55,131.55	64,985.87	37,151.16	27,834.71
Deductions Total	222,774.10	134,764.19	88,009.91	381,129.98	269,528.38	111,601.60
COST RECOVERIES						
Grants	99,473.80	40,807.91	58,665.89	99,473.80	81,615.82	17,857.98
In-Kind Contributions	105,860.12	101,453.67	4,406.45	188,334.66	202,907.34	-14,572.68
Other Revenue	6,813.48	63,287.58	-56,474.10	12,736.79	126,575.16	-113,838.37
Cost Recoveries Total	212,147.40	205,549.16	6,598.24	300,545.25	411,098.32	-110,553.07
TOTAL REVENUES	758,986.29	840,114.31	-81,128.02	1,363,883.72	1,680,228.62	-316,344.90
EXPENSES						
Wages	281,777.14	294,438.56	-12,661.42	560,004.70	588,877.12	-28,872.42
Taxes & Benefits	171,032.29	201,962.50	-30,930.21	374,152.70	403,925.00	-29,772.30
Professional Services	195,527.58	180,625.27	14,902.31	395,889.84	361,250.54	34,639.30
Minor Equipment	14,932.27	1,447.83	13,484.44	17,043.57	2,895.66	14,147.91
Supplies	40,213.60	36,269.75	3,943.85	60,380.54	72,539.50	-12,158.96
Repairs & Maintenance	556.73	8,797.83	-8,241.10	3,123.07	17,595.66	-14,472.59
Rents & Leases	10,709.93	10,196.99	512.94	11,575.48	20,393.98	-8,818.50
Utilities	100,969.60	47,299.67	53,669.93	201,292.77	94,599.34	106,693.43
Travel & Training	2,906.99	4,340.93	-1,433.94	6,223.00	8,681.86	-2,458.86
Insurances	30,413.51	17,220.74	13,192.77	44,281.24	34,441.48	9,839.76
Recruit & Relocate	2,796.81	7,838.34	-5,041.53	3,568.06	15,676.68	-12,108.62
Depreciation	42,143.47	22,360.92	19,782.55	83,306.11	44,721.84	38,584.27
Other Expenses	14,701.71	9,151.09	5,550.62	22,695.02	18,302.18	4,392.84
TOTAL EXPENSES	908,681.63	841,950.42	66,731.21	1,783,536.10	1,683,900.84	99,635.26
OPERATING INCOME	-149,695.34	-1,836.11	-147,859.23	-419,652.38	-3,672.22	-415,980.16
NET INCOME	-149,695.34	-1,836.11	-147,859.23	-419,652.38	-3,672.22	-415,980.16

CMS Finalizes the 60-Day Parts A and B Overpayment Return Rule

March 2016

Medicare providers must report and repay any Medicare Parts A and B overpayments within 60 days of identifying them, according to a final rule released Feb. 11, 2016. The final rule is effective March 14, 2016 and includes a 6-year lookback period.

It is important for hospitals to promptly investigate and disclose any repayments to The Centers for Medicare and Medicaid (CMS) or the Medicare Administrative Contractor (MAC).

Highlights/Overview

Healthcare providers must repay an overpayment and notify the federal government, the state and any "intermediary carrier or contractor to whom the overpayment was returned in writing of the reason for the overpayment," all within 60 days of first identifying the overpayment.[1]

Identifying an overpayment should occur when a provider verifies an overpayment has been received, after exercising due diligence.

- CMS defines reasonable due diligence as "proactive compliance activities to monitor claims and reactive investigative activities undertaken in response to receiving credible information about a potential overpayment."

The 60-day period begins after a provider has determined an overpayment has occurred once reasonable diligence has been completed or on the day the provider received credible information of a potential overpayment, if the provider does not engage in reasonable diligence. The period for reasonable diligence is not to exceed six months from receipt of credible information, excepting extraordinary circumstances.

CMS clarified there is no overpayment if the identified error did not result in an increase in reimbursement, and also clarified that where there is a reimbursement increase, the overpayment is only the difference between what was paid and what should have been paid if the claim had been submitted correctly.

Lookback Period

- CMS reduced the lookback period to six years as opposed to 10 years, which was originally stated in the proposed rule:
  - Overpayments must be reported only if a person identifies the overpayment within six years of the date the overpayment was received.

(Continued)

CMS Finalizes the 60-Day Parts A and B Overpayment Return Rule (Continued)

- Reducing the lookback period allows providers to use all approved mechanisms for refunding overpayments, such as the adjustment claim process.
- Scot Hasselman, an attorney with Reed Smith in Washington, told Bloomberg BNA: "Many providers and suppliers will be unable to conduct their own lookback and will have to hire third parties to do it for them. And, because limitation periods will have ended, or because record retention policies permitted earlier destruction, necessary documentation may not be available."
- Potential costs and resources necessary for a six-year lookback should not be minimized.

Potential Liabilities

- Providers and suppliers are subject to potential False Claims Act (FCA) liability, civil monetary penalties and exclusion from federal healthcare programs for failure to report and return an overpayment.
- Providers and suppliers will continue to be required to comply with current procedures when CMS, or its contractors, determine an overpayment and issue a demand letter.

Methods for Reporting and Returning Overpayments

- Providers and suppliers must use applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to report and return overpayments.

Provider/Supplier Costs

- CMS projects that the time and effort necessary for providers and suppliers to identify, report and return overpayments as set forth in this Final rule will result in an annual cost of between $120.87 million and $201.45 million.
- CMS' mid-range projection is an estimate of $161.16 million.

Summary

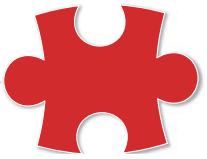
- This final rule gives providers more time to thoroughly investigate for prior overpayments and make one repayment, rather than requiring them to conduct a rushed review or submit piecemeal repayments.
- According to CMS, the Final Rule:
  - Ensures compliance with applicable statutes;
  - Promotes high quality care; and
  - Protects the Medicare Trust Fund against fraud and improper payments.

Two documents providing more information on this issue are attached for your review: "Medicare and Medicaid Guide," and Bloomberg BNA's "Medicare Report." [1] Section 6402(a) of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), which created a new section 1128J (d) of the Social Security Act, requires a provider or supplier who received an overpayment to report and return the overpayment to the HHS Secretary, the state, an intermediary, a carrier, or a contractor at the correct address and to notify the respective recipient of the overpayment in writing of the reason for the overpayment.

QVIEW
MARCH 2016
Quorum's Monthly Digest of the Business of Healthcare

URGENT CARE FACILITIES FILLING GAPS IN HEALTHCARE

Consumer Touchstone



Urgent care centers are popping up everywhere. And while "urgent care" is not meant to address life-threatening conditions, these facilities are "becoming the bridge between the primary care doctor's office and the hospital emergency room (ER)," reported ***NPR***. Currently, urgent care centers boast "nearly 7,100 locations in the U.S., according to the most updated number from the Urgent Care Association of America," (*Becker's Hospital Review*). Further, this already broad national footprint is expected to continue to grow. According to *Health Facilities Management (HFM)*, the "$14.5 billion urgent care industry is expected to increase 5.8 percent annually through 2018 to about $18.8 billion, according to a report by investment banking service firm Harris Williams & Co."

Urgent care centers meet gaps in care often due to scheduling conflicts with primary care doctors. In a recent poll conducted by *NPR*, the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health, "one in five people reported going to urgent care at least once in the past two years, [because] they were unable to see their regular doctor when they needed medical care."

In addition to scheduling conflicts, consumers are demanding more convenient access to care. *Becker's Hospital Review* explains that "as healthcare shifts toward the outpatient arena, urgent care centers remain popular with patients and consumers looking to receive convenient and affordable treatment for minor conditions, imaging and blood tests." Cost is also driving the growth of urgent care facilities, which offer a cheaper alternative to the ER. *NPR* reports that "according to a recent review from the National Center for Health Statistics, visits to the ER can easily run more than $1,000 for adults. The average visit to an urgent care center, in contrast, hovers around $150."

Another factor contributing to the proliferation of urgent care centers is that many Americans do not have a primary care physician. According to a 2015 report by Salesforce, "nearly half of people ages 18-34 (millennials) do not have a personal relationship with a physician," *(USA Today)*.

The physician shortage is challenging patients of all ages too. Many primary care practices are full and people cannot find a physician who is taking new patients. Dr. Andrew J. Sussman, president of MinuteClinic, the CVS-owned company, said about half of MinuteClinic patients have no other source of care. Dr. Sussman told the Boston *Globe*, "We want to be able to provide patients with timely care so it doesn't get worse," and more expensive to treat, he said. "There's a profound shortage of primary care physicians. Retail clinics can help keep patients healthy."

Urgent care centers should be part of a hospital's system of care. "The beauty of [an] integrated system is that primary care, urgent care and hospital care are all connected, so medical records are shared. Not only is that sort of system more efficient, "he says, "but patient care is improved, too," *(NPR)*.

Several Quorum client hospitals have created urgent care centers to meet the needs of their community. One example is Northwestern Medical Center (NMC) in St. Albans, VT. "NMC established two urgent care centers as part of our strategic effort to reduce avoidable visits to the ED," said Jonathan Billings, NMC's vice president of Planning & Community Relations. "We are very pleased that both of our urgent care locations have exceeded volume predictions, with each site averaging 30-40 patients per day. Even more so, we are thrilled that our patient satisfaction is typically very high—ranking above the 90th percentile." In addition, Billings reported that the urgent care sites have also contributed to a measurable reduction in avoidable visits to the NMC ED.

Talk to your CEO about your hospital's strategy to meet the primary care needs of your community, and the role of urgent care centers. You can also discuss what other hospitals are doing in your region with your Quorum regional vice president.

References

Quotations in the text are drawn from the following sources:

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CMS finally codifies the 60-day Parts A and B overpayment return rule

CMS codified the longstanding responsibility of providers and suppliers to report and return Medicare Parts A and B overpayments. Specifically, the Final rule requires health care providers and suppliers receiving funds under the Parts A and B programs to report and return overpayments by the later of the date that is 60 days after the date an overpayment was identified, or the date any corresponding cost report is due. The Final rule also clarifies when an overpayment is identified, the required lookback period for overpayments, and the methods available for reporting and returning identified overpayments to CMS. The new regulations are effective March 14, 2016.

Statutory basis

Section 6402(a) of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), which created a new section 1128J(d) of the Social Security Act, requires a provider or supplier who has received an overpayment to report and return the overpayment to the HHS Secretary, the state, an intermediary, a carrier, or a contractor at the correct address, and to notify the respective recipient of the overpayment in writing of the reason for the overpayment. Section 1128J(d)(2) requires that an overpayment be reported and returned by the later of: (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable.

Potential liabilities

Section 1128J(d)(3) specifies that any overpayment retained by a provider or supplier after the deadline for reporting and returning an overpayment is an "obligation" (as defined in 31 U.S.C. §3729(b)(3)) for purposes of the federal False Claims Act (FCA) (31 U.S.C. §3729). Therefore, even without this Final rule, providers and suppliers were subject to potential FCA liability, civil monetary penalties, and exclusion from federal health care programs for failure to report and return an overpayment. Even with the issuance of this Final rule, providers and suppliers will continue to be required to comply with current procedures when CMS, or its contractors, determine an overpayment and issue a demand letter.

CMS twice proposed, but did not finalize, rules that would have amended its regulations to codify this overpayment return responsibility (63 FR 14506, March 25, 1998; and 67 FR 3662, January 25, 2002). On February 16, 2012 (77 FR 9179), CMS published the Proposed rule upon which this Final rule is based.

Overpayment identification

Under the Final rule, a provider or supplier is deemed to have "identified" an overpayment when they have or should have, through the exercise of reasonable diligence, determined that they received an overpayment, and quantified the amount of the overpayment. CMS believes this standard provides needed clarity and consistency for providers and suppliers on the actions they need to take to comply with requirements for reporting and returning of self-identified overpayments.

In an interview with Wolters Kluwer, Robert L. Roth of Hooper, Lundy & Bookman, P.C. took a slightly different view. Roth believes "the clarifications regarding 'identified' are a mixed bag—somewhat helpful but potentially costly to providers." For example, Roth said, "while is it helpful to have additional clarification regarding the time for investigation and quantification, CMS provides no basis for its conclusion that a 'total of eight months (six months for timely investigation and two months for reporting and returning) is a reasonable amount of time, absent extraordinary circumstances.'" Moreover, Roth points out "the Final rule expects provider compliance activities to be not only 'reactive . . . in response to receiving credible information about a potential overpayment,' but also 'proactive...to monitor claims,' with limited guidance about the metes and bounds of that expectation." Roth concludes, "satisfying that expectation for smaller providers may mean hiring additional staff or contracting for additional compliance services." It is unclear to Roth what CMS' legal authority is for that expectation.

Lynn M. Adam of King & Spaulding LLP believes "providers and suppliers that file claims under Medicare Parts A and B will find it helpful that the overpayment clock is not triggered until the amount of the overpayment is 'quantified.'" As a result, according to Adam, "so long as a provider exercises reasonable diligence to investigate and quantify the overpayment, the report and refund deadline will now be easier to calculate." Adam cautions, however, that because "CMS also expressed the view that a timely investigation should be completed within six months from receipt of credible information about an overpayment, that timeframe could be difficult to meet depending on the circumstances."

Lookback period

The Final rule requires that overpayments must be reported and returned only if a person identifies the overpayment within six years of the date the overpayment was received. According to Roth, it was important that CMS "reduced the [proposed] lookback period from 10 years to six years, which allows providers to use all approved mechanisms for refunding overpayments, such as the adjustment claim process."

Methods for reporting and returning overpayments

Under the Final rule, providers and suppliers must use applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to report and return overpayments. This will preserve CMS' existing processes and its ability to modify these processes or create new processes in the future.

Suspension of deadline

The Final rule provides that the deadline for returning overpayments will be suspended when:

- the HHS Office of Inspector General (OIG) acknowledges receipt of a submission to the OIG Self-Disclosure Protocol or CMS acknowledges receipt of a submission to its Voluntary Self-Referral Disclosure Protocol. In either situation, the suspension will remain in effect until (1) a settlement agreement is entered with the OIG or CMS; (2) the provider or supplier withdraws from the OIG Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol; or (3) the provider or supplier is removed from either of the protocols.
- a provider or supplier requests an extended repayment schedule. In this situation, the deadline will remain suspended until CMS, or one of its contractors, rejects the extended repayment schedule request or the provider or supplier fails to comply with the terms of the extended repayment schedule.

Other industry concerns

Roth points out "although fundamentally about overpayments, the scope of this Final rule is vast and touches on compliance plans, Stark, kickbacks, appeals, reopening, limitation on liability, use of sampling, Medicare secondary payer, and more." Roth concludes that while "the Final rule pretty much addressed the issues in the Proposed rule, one particularly unsatisfying aspect . . . is the short shrift that CMS gave to provider concerns about its narrow definition of the 'applicable reconciliation' processes provided by law that would avoid the creation of a report and return obligation under this rule. The definition of such reconciliation processes that cause an overpayment to fall out of the ambit of the rule did not change between the Proposed and Final rule, over significant provider objections."

Adam is concerned that the Final rule "does not clarify the nuanced distinctions that exist in the overpayment rules for different federal programs." She points out "CMS has not issued overpayment rules for the Medicaid program," despite the fact that "the law requires Medicaid overpayments to be

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reported and returned by the same deadline, and there are still questions about when a Medicaid overpayment is 'identified.'"

Adam also reminds us "although CMS issued a Final rule for Medicare Parts C [42 C.F.R. sec. 422.326] and D [42 C.F.R. sec. 423.360] in May 2014 [79 FR 29844], those regulations take a different approach to identifying overpayments." Because some providers submit claims to all of these programs, Adam cautions them to be mindful of these distinctions (see *Medicare Parts C and D 2015 participation requirements and payment accuracy addressed*, May 27, 2014).

Provider/supplier costs

CMS projects that the time and effort necessary for providers and suppliers to identify, report, and return overpayments as set forth in this Final rule will result in an annual cost of between $120.87 million and $201.45 million. CMS' mid-range projection is an estimate of $161.16 million.

Benefits

According to CMS, the benefits of this Final rule include ensuring compliance with applicable statutes, promoting the furnishing of high quality care, and the protection of the Medicare Trust Funds against fraud and improper payments. CMS admits that the potential financial benefits of this Final rule from the standpoint of its effectiveness in recouping overpayments are not easily quantifiable, because it does not have sufficient data on which to base a monetary estimate of recovered funds. ■

Final rule, 81 FR 7654, February 12, 2016, ¶181,301

Court must decide whether to clear the RAC appeal logjam with mandamus

The D.C. Circuit Court of Appeals ruled that the district court must consider the merits of the American Hospital Association's request for mandamus ordering HHS to decide claims appeals within the statutory deadlines. The district court incorrectly conflated the question of jurisdiction with the merits when it dismissed the AHA's complaint (see *Court refuses to break the "logjam" of Medicare appeals*, December 22, 2014).

Statutory deadlines

The AHA'S mandamus action sought to enforce the deadlines set in 42 U.S.C. §1395ff for the completion of each stage of the administrative review process. In particular, review by an administrative law judge (ALJ) is required to be completed within 90 days of timely filing of a petition for review, and review by the Departmental Appeals Board (DAB) must be completed within 90 days of receipt of the request for review.

Burgeoning RAC appeals

When HHS implemented the recovery audit contractor (RAC) program, appeals from overpayment determinations by RACs were added to the existing load of claims appeals. The number of appeals filed for ALJ review went from about 59,600 in federal fiscal year (FFY) 2011 to more than 384,000 in FFY 2013. By July 2014, the number of pending appeals reached 800,000. Even with increased staffing and streamlined procedures, the ALJs can process only about 72,000 appeals per year. In December 2013, the agency suspended the assignment of new appeals to the dockets for at least the next two years.

Jurisdiction

The Court of Appeals explained that there are three elements necessary to support jurisdiction over a mandamus claim: (1) a clear, indisputable right to relief; (2) violation by the government of a clear duty to act; and (3) the existence of no other adequate remedy. Once jurisdiction has been established, in challenges to agency delays, the court must consider six other related factors to determine whether the delay is egregious. The trial court had considered all of these issues together.

The existence of a clear duty to act and a corresponding clear right to relief were established because the deadlines are set forth in the statute. HHS argued that the ability to escalate an appeal to the next level, including judicial review, either made the duty a direction or provided an adequate remedy. The court rejected both of these contentions, however. The existence of a consequence for noncompliance did not negate the existence of the duty to timely dispose of cases. Escalation was not an adequate remedy because review by the ALJ is de novo, a fresh look at the record, while judicial review is highly deferential to the agency's actions. Therefore, the court ruled that the district court had jurisdiction over the mandamus claims. It then addressed the factors that the court should consider when it decides the merits.

Addressing the merits

When it decides whether the agency's delay is egregious enough to justify mandamus, the district court must consider the current backlog rather than the situation as it was when the original hearing was held. The court anticipates that the backlog will be much worse. Factors that might weigh against mandamus include: (1) the extraordinary, intrusive nature of the writ; (2) the extent to which Congress is attending to the issue; (3) the availability of escalation; and (4) the agency's good faith efforts to solve the problem. Factors weighing for mandamus include: (1) the impact on human health and welfare, as hospitals must defer repairs, cut services, or decline certain patients who may be more likely to trigger an audit; (2)

the discretion given to the Secretary over the details of implementation of the RAC program; and (3) the extent to which Congress and the agency are making progress toward elimination of the backlog.

The court noted that regardless of the limits on its resources, the agency could not delay appeals indefinitely. Although the RAC program is successful, the statutes make timely processing of appeals mandatory and the extent of implementation of the RAC program discretionary. The statutory mandates must prevail over discretionary actions. Finally, the court strongly suggested that the district court might require the agency to make periodic status reports so that it could monitor progress and, if needed, order mandamus if necessary. ■

American Hospital Association v. Burwell, D.C. Circuit, February 9, 2016, ¶305,539

ACA can't retroactively rescue hospital's reimbursement

A district court held that a provision of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) related to hospital reimbursement for offsite graduate medical education training did not apply to a hospital's cost reimbursement for 2003 and 2004 despite the fact that an appeal of the hospital's cost reimbursement was still pending at the time of the ACA's enactment. The court reasoned that the ACA provision could not be applied retroactively and, therefore, the hospital was not entitled to reimbursement for the offsite training rotations due to documentation that was lacking under pre-ACA documentation rules.

Rotations

Eastern Maine Medical Center operates a family practice residency program of graduate medical education. The hospital obtains Medicare reimbursement for a share of the direct and indirect costs of operating the residency program. The program consists of 52 week-long rotations for three years. The program offers "inside rotations," which take place exclusively on the hospital campus, and off-site rotations, known as "outside rotations."

Audit

Following an audit of the outside rotation schedules, a Medicare administrative contractor (MAC) disallowed several reimbursement requests for the costs of outside rotations for 2003 and 2004. When the hospital provided additional documentation, the MAC allowed more, but not all, of the rotations. The reasons for the disallowance included the absence of agreements between the hospital and the physicians who volunteered to supervise the outside rotations, agreements with those volunteer physicians that were not signed until after the rotations took place, and instances where the agreement was otherwise improperly documented. Although the hospital agreed with some of the disallowances, it appealed the MAC's ruling to the Provider Reimbursement Review Board (PRRB).

Administrative review

The PRRB ruled that the MAC's decision conflicted with Section 5504(c) of the ACA, which rendered the issue of compensation for outside teaching physicians irrelevant. The PRRB held that for the appeals that were jurisdictionally proper at the time of the ACA's enactment, the more lenient documentation provisions of the ACA should be applied. Therefore, the PRRB reasoned that the hospital could be reimbursed for the outside rotations despite the lacking documentation (see *Intermediary ordered to re-audit resident rotations using post-ACA provisions*, June 4, 2014). The CMS Administrator reviewed the PRRB decision and disagreed with the PRRB, holding that Section 5504(c) did not retroactively apply to the pending appeals. The CMS Administrator also reviewed the disallowed outside rotations and held that, under pre-ACA rules, reimbursement for an outside rotation required a written agreement with the off-campus physician specifying the amount of compensation paid for supervisory teaching activities, even if the compensation was nothing. The CMS Administrator also held that the agreement needed to be in writing prior to the beginning of the rotation. Thus, the CMS Administrator reinstated the MAC's findings (see *ACA graduate medical education changes do not apply retroactively*, August 14, 2014).

ACA

The hospital appealed the issue to a district court and asked the court to reinstate the PRRB decision. The hospital asserted that the language of Section 5504(c)—"shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending"—required that the new standard be applied to the outside rotation reimbursement decision. The court disagreed and held that hospital could not take advantage of the new ACA provisions because the agency's determination that the provision only applied to cost reports after the ACA's enactment was a reasonable interpretation of the statute.

Pre-ACA law

The court then applied the pre-ACA rules regarding reimbursement of outside rotations. The court explained that under the earlier law, a hospital could obtain reimbursement only if the hospital incurred "all, or substantially all of the costs for

the training program in that [offsite] setting." To prove that the hospital met those standards, it needed to provide documentation of the written agreements it had with the outside teaching physicians. The court held that because the hospital merely stated that it was not compensating the outside physicians, without providing adequate documentation to prove that fact, the hospital could not demonstrate that it met the standard of incurring "all, or substantially all the costs for the training program." The court explained that the written physician agreements were required for reimbursement for the outside rotations. ■

Eastern Maine Medical Center v. Burwell, D. Me., February 9, 2016, ¶305,540

Disputes over payments for out-of-network services subject to administrative review

A health care system's claims against a Medicare Advantage (MA) plan for recouping payments were dismissed in federal court, because the health organization failed to exhaust its administrative remedies. The U.S. District Court for the Northern District of Georgia found that the claims of Tenet Healthsystem GB, Inc. (Tenet) against Care Improvement Plus South Central Insurance Company (Care Improvement) were "inextricably intertwined with a claim for Medicare benefits" and subject to administrative exhaustion requirements, even though the claims involved post-payment audits.

Out of network services

Care Improvement provides MA coverage for Medicare beneficiaries who choose to enroll in privately managed plans and pay premiums for additional benefits. CMS also pays Care Improvement a fixed amount for each enrollee, and then Care Improvement pays for the care provided to enrollees regardless of whether CMS' monthly payments or the enrollee's premiums cover the costs of care. Providers participating in an MA's network are reimbursed for services. In this case, Tenet's various health care facilities did not have contracts with Care Improvement, but some Medicare enrollees covered by Care Improvement required treatment from these facilities.

Audits

Tenet stated that it obtained authorizations from Care Improvement to provide services in exchange for a promise of reimbursement. By doing this, Tenet waived its right to receive direct payment from the beneficiary patients. Although Care Improvement paid the submitted bills in full, it later conducted post-payment audits and then recouped substantial sums from Tenet. Although Tenet claimed to have challenged these recoupments, Care Improvement refused to return the payments.

Administrative process

The Medicare Act requires MA plans to cover emergency services even when they are provided by providers outside of the plan's network, limited to the amount the provider would collect if the beneficiary was covered by original Medicare (42 U.S.C. §1395w-22(d)(1)(E); 42 C.F.R. section 422.214(a)). All attempts to recover on claims "arising under" the Medicare Act are subject to the administrative appeals process, including a provider requesting a determination related to payment from an MA plan for out-of-network services (42 C.F.R. section 422.566).

Tenet argued that the payment decisions were not MA organization determinations, and therefore were not subject to the administrative process. It pointed to a case in which the Fifth Circuit determined that claims for breach of contract, fraud, reliance, and violations of state law were not "inextricably intertwined" with claims for benefits. In contrast, Care Improvement pointed to other case decisions in which courts found that disputes between parties that did not have a network contract were "governed by a complex federal regulatory scheme." The Georgia court was persuaded by Care Improvement, finding that because the two parties did not have a contractual relationship, CMS standards and Medicare regulations govern the relationship and the claims are therefore required to proceed through the administrative process. The court dismissed the case. ■

Tenet Healthsystem GB, Inc. v. Care Improvement Plus South Central Insurance Company, N.D. Ga., February 11, 2016, ¶305,541

Hospital has itself to blame for unpaid Medicare claim

A district court dismissed a hospital's suit for Medicare reimbursement because the court lacked subject matter jurisdiction to hear the case. The court explained that it lacked jurisdiction because the hospital failed to present a valid claim to HHS and did not exhaust available administrative remedies prior to filing its lawsuit. The court also declined to provide equitable relief because the hospital failed on its own accord to submit a proper claim prior to Medicare's one-year deadline despite being notified by a Medicare Administrative Contractor (MAC) of the need to resubmit its claim.

Claim

Select Specialty Hospital-Ann Arbor, Inc. treated a Medicare beneficiary from December 27, 2012 through April 12, 2013 following complications from a methylprednisolone acetate (MPA) injection for joint pain. The patient filed a products liability lawsuit against the manufacturer of the MPA injection. While that case was pending, the hospital submitted a claim requesting a conditional payment totaling $501,515.23 for the patients care. The claim was premised on the condition that Medicare would be reimbursed from any lawsuit settlement proceeds. Novitas Solutions, Inc., the MAC, rejected the claim due to a coding discrepancy that was inconsistent with the conditional payment the hospital was seeking from Medicare. The MAC notified the hospital explaining the code discrepancy and directing the hospital to make the correction. The hospital did not correct the coding error and failed to resubmit the claim prior to the one-year deadline established by 42 C.F.R. Sec. 424.44(a)(1).

Lawsuit

The Hospital filed a lawsuit seeking declaratory and injunctive relief. Medicare moved to dismiss the lawsuit on the grounds that the court lacked subject matter jurisdiction because the hospital did not exhaust available administrative remedies prior to turning to the court. The hospital countered that it should not need to exhaust administrative remedies because the process would be futile, as a Medicare administrative contractor gave the hospital erroneous information. The hospital asserted that a MAC employee instructed the hospital to use the code that was later rejected. The hospital also claimed that the same employee directed the hospital not to resubmit the claim on the grounds that it would be futile to do so because Medicare would not pay the claim until the products liability lawsuit was resolved. The hospital allegedly believed its claim had been denied and could not be resubmitted. The hospital asked the court to toll Medicare's one-year deadline so that the hospital could resubmit its claim for reimbursement.

Jurisdiction

The court indicated that it was sympathetic to the hospital's dilemma but held that HHS had to first be given the opportunity to decide how to apply its own policies and regulations before a court could intervene into the question. The court agreed with HHS that the claim was never denied but rejected and then never resubmitted. Therefore, the court explained, HHS was never given an opportunity to make an initial claim determination—a necessary prerequisite to subject matter jurisdiction. The court held that the hospital could not satisfy either the claim presentment or administrative remedy exhaustion requirements necessary for subject matter jurisdiction. Thus, because 42 U.S.C. § 405(g) requires a final HHS determination prior to judicial review, the court dismissed the claims.

Equity

The court also held that it would not apply equitable estoppel or toll the one-year deadline and allow the hospital to properly resubmit its claim. The court first explained that equitable estoppel could not be used to establish subject matter jurisdiction. The court also held that equitable relief was improper because despite the fact that the MAC sent the hospital a rejection notice directing the hospital to correct its error and resubmit its claim, the hospital failed to act. ■

Select Specialty Hospital Ann Arbor, Inc. v. HHS, E.D. Mich., February 8, 2016, ¶305,537

Estate recovery cannot reach back before rules were in place

Four Medicaid beneficiaries received adequate notice that the Michigan Medicaid agency would claim an interest in their estates to repay the state for Medicaid expenditures. Nevertheless, because Mich. Comp. L. sec. 112g provided that the estate recovery program would be implemented only after CMS approved it, the state agency could not recover for expenditures made before the recovery program was implemented.

Michigan's estate recovery program

Soc. Sec. Act sec. 1917 required states to establish estate recovery programs to seek reimbursement for the cost of long-term care services. Michigan enacted its statute in 2007. In 2010 the state submitted a proposed state plan amendment (SPA), including rules and procedures, to CMS for approval. CMS approved the SPA the next year and issued instructions to agency employees several weeks later.

The state statute contained conflicting provisions on the timing of notice to the beneficiaries that the agency would seek reimbursement from their estates. One paragraph stated that the notice should be given at enrollment; the other stated that notice should be provided to individuals "seeking Medicaid eligibility."

It was undisputed that all of the beneficiaries applied for assistance before 2010 and that none of them were given notice of the estate recovery program on application. Each beneficiary had to submit additional information for an annual redetermination of eligibility, however. Beginning in 2012, that documentation included an acknowledgement that the agency would make a claim against the beneficiary's estate.

Due process

The court followed a 2015 decision that due process requirements were satisfied because the estates had the opportunity to contest the estate recovery in probate court. However, the estates argued that the beneficiaries had been denied due process because the state's failure to notify them of the recovery program at application or while they were receiving benefits deprived them of the opportunity to choose whether to receive assistance or to preserve their estates.

The court was sympathetic to that argument but did not expressly rule that the beneficiaries had been deprived of due process. Rather, it ruled that the state agency could not enforce its claims before the date that the state law was implemented by instructing the agency to carry out the approved state plan amendment.

Additional ruling

One of the estates also argued that the recovery violated Mich. Comp. L. sec. 400.112g(4), which provides that the state should not seek reimbursement if the cost of doing so would be greater than the amount recovered or if recovery was not in the best interests of the state. Because the trial court had not considered this issue, that case was remanded for determination of the cost of recovery and the best interests of the state. ■

In re: Estate of Gorney, Mich. App., February 4, 2016, ¶305,538

AHRQ seeks new measures to measure organizations' health literacy

The Agency for Healthcare Research and Quality (AHRQ) published a call for quality measures that address the question of health care organizations' "health literacy," defined as the organizations' "implementation and monitoring of organizational policies, practices, and structures that support patients in understanding health information, navigating the health care system, and managing their health.".

Areas of focus

The AHRQ seeks to test and measure how health care organizations help patients and caregivers to: (1) understand the health care information that they receive; (2) navigate the health care system; (3) "engage in the health care process;" and (4) actively and effectively manage their own health. Toward that end, the AHRQ seeks measures to be used to identify and monitor progress toward those goals across four domains, i.e., communication, navigation of the health care system; patient engagement and self-management; and organizational policies and structures.

The agency's request specifically excludes any measures that require patient surveys. Rather, it seeks measures that can be derived from other available data such as electronic health records or internal monitoring and that have been or can be used to progress toward increasing patients' understanding, simplifying their navigation through the system, and actively managing their care.

Submission process

The notice specifies the information that the AHRQ seeks about proposed measures, including:

- Who has developed or used the measure;
- What data is used and where it comes from;
- Who is responsible for collecting the data;
- Which of the four domains it addresses;
- What actions have been taken based on use of the measure; and
- Any unintended negative consequences that arose.

The deadline for submissions is March 4, 2016. ■

Notice, 81 FR 7116, February 10, 2016, ¶263,866

The 2016 poverty line: $24,300 for a family of four

The poverty guideline for 2016 is $24,300 for a household of four in the 48 contiguous states and the District of Columbia. The annual update sets the poverty guideline for an individual in the 48 contiguous states and D.C. at $11,880. The poverty guidelines, which are derived from the Census Bureau's current official poverty thresholds, are roughly equal to the thresholds from 2015.

Alaska and Hawaii

There are separate poverty guidelines for Alaska and Hawaii. In Alaska, the poverty guideline for an individual is set at $14,840 and the guideline for a family of four is set at $30,380. In Hawaii, the poverty guideline for an individual is set at $13,670 and the guideline for a family of four is set at $27,950.

Program eligibility

When determining eligibility for programs like Medicaid, CHIP, and the advance payments of the premium tax credit (APTC) payments and cost-sharing reductions (CSR) under the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), the federal government relies on a percentage multiple of the guidelines. While the federal government will begin using the 2016 poverty guidelines for Medicaid and CHIP eligibility on March 4, 2016, the federal government will continue to use the 2015 guidelines to calculate eligibility for APTC and CSR for enrollment effective in 2016. ■

CMCS Informational Bulletin, February 9, 2016, ¶54,177

Implementation of ACA pricing requirements for outpatient drugs

New guidance instructs state Medicaid agencies on the requirements for pricing covered outpatient drugs under the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). The guidance clarifies and supplements the Final rule published February 1, 2016, listing the key changes and the items that must be addressed in any proposed state plan amendment (SPA).

Actual acquisition cost

As recently amended, 42 C.F.R. §447.512(b) requires states to reimburse pharmacies for certain drugs based on their actual acquisition cost (AAC) plus a reasonable professional dispensing fee. The state may determine AAC in any of four ways: (1) by surveying retail pharmacies; (2) by using a national survey such as the National Average Drug Acquisition Cost (NADAC); (3) consulting published compendia, such as the wholesale acquisition cost, or (4) using the average manufacturer price (AMP).

If the state agency uses published compendia, it must adjust for discounts and other price concessions. If it uses AMP, it must establish the relationship between AMP and any markups.

Professional dispensing fee

CMS now describes the dispensing fee as a professional dispensing fee to emphasize that it is supposed to cover the cost of the pharmacist's professional services to dispense the drug. CMS did not establish any particular methodology for calculation of the dispensing fee. Any SPA relating to payment for covered outpatient drugs must address both the AAC and the dispensing fee.

Multiple source drugs and FULs

ACA sec. 2403 amended Soc. Sec. Act sec. 1927(e) to require that CMS establish federal upper limits (FULs) for three or more drugs that are determined to be pharmaceutically and therapeutically (P&T) equivalent. CMS will establish the FULs based on 175 percent of the most recent weighted AMP as provided in the statute. Only drugs that are listed as A-rated equivalent on the National Drug Code work sheet will be subject to the FUL. If CMS determines that the cost to retail pharmacies exceeds the FUL it will use a higher multiplier than the 175 percent provided in the statute.

CMS will not publish a FUL for multiple source drugs that have no corresponding acquisition cost or for drugs that have multiple per-unit acquisition costs.

State plan amendments

States will have one year to submit their SPAs to comply with the final rule, which becomes effective April 1, 2016. As they prepare their state plans they must be sure to comply with the requirements for opportunities for public comment and consultation with Indian Health Service (IHS), Indian tribes, and urban Indian organizations.

The prices for drugs dispensed by entities or pharmacies covered by the 340B program or by IHS or tribal or urban Indian organization pharmacies must comply with 340B limits or the AA requirements of 42 C.F.R. sec. 447.502, as applicable, The SPA must comprehensively describe the state's methodology and the data sources used, including the manner in which the state will update its data and prices. ■

CMS Letter to State Health Officials, No. SMD-16-001, February 11, 2016, ¶54,178

Siblings fired for sharing information of 91,000 Washington Medicaid recipients

The Washington Health Care Authority (HCA) is sending letters to 91,000 Apple Health (Medicaid) recipients to notify them of a breach of protected health information (PHI) following improper handling by an HCA employee. The employee sought technical help from her brother, an employee of the Department of Social and Health Services (DSHS), and in doing so, provided him with information, including clients' Social Security numbers, dates of birth, addresses and phone numbers, Apple Health identification numbers, and medical procedure and diagnosis information. Although there is no evidence that the information was used improperly, the HCA could not verify that the information remained within the state system.

Health Information Portability and Accountability Act (HIPAA) (P.L. 104-191) covered entities (CEs)—health plans, health care clearinghouses, and health care providers that transmit health information electronically in connection with certain transactions—must notify patients when their PHI has been compromised, a process referred to as "breach notification" (sec. 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA) (P.L. 111-5)). CEs must notify patients of breaches unless they actually demonstrate a low probability that PHI was compromised (78 FR 5566).

In this instance, the HCA employee, a medical assistance specialist, exchanged emails containing PHI with her brother, an internet technician, from 2013 to 2015, while she asked him for technical assistance with spreadsheets containing PHI. The exchanges were uncovered during the course of a whistleblower investigation of misuse of state resources. Because of a viable possibility that PHI was leaked outside of the system, the HCA was required to notify affected individuals.

The HCA is offering one year of free credit monitoring to Apple Health clients affected by the breach. The HCA and the DSHS terminated both employees. ■

Wolters Kluwer News Bureau, February 9, 2016

OTHER DECISIONS AND DEVELOPMENTS

CMS Transmittals

Contractor Reporting of Operational and Workload Data (CROWD) Form 5 Update with Revisions to Pub. 100-06 Medicare Financial Management Manual, Chapter 6. *Medicare Financial Management Manual*, Pub. 100-06, Transmittal No. 263, February 5, 2016, ¶161,709.

Comprehensive Error Rate Testing (CERT) program Treatment of Claims in the Prior Authorization Model. *Medicare Program Integrity Manual*, Pub. 100-08, Transmittal No. 637, February 5, 2016, ¶161,710.

Using scrubbed Medicare beneficiary/legal rep address data within the Fee-For-Service (FFS) systems - Analysis and Design. *One-Time Notification Manual*, Pub. 100-20, Transmittal No. 1623, February 5, 2016, ¶161,711.

Identifying "No Documentation" Medical Necessity Denials for Claims Flagged for Recovery Auditor Review. *One-Time Notification Manual*, Pub. 100-20, Transmittal No. 1625, February 5, 2016, ¶161,712.

Proposed Rules

Confidentiality of substance use disorder patient records. *Proposed rule*, 81 FR 6988, February 9, 2016, ¶220,964.

Notices

Medicare Program: notice of seven membership appointments to the advisory panel on hospital outpatient payment. *Notice*, 81 FR 7345, February 11, 2016, ¶263,867.

Notice of computer matching program; Privacy Act of 1974. *Notice*, 81 FR 6863, February 9, 2016, ¶263,868.

PRRB Decisions

PRRB Jurisdictional Decisions for October 2015. *PRRB Hearing*, Dec. No. JD-2015-10, October 28, 2015, ¶83,042.

DAB Decisions

Reassignment of benefits cannot be effective before practice's enrollment date. The earliest date a physician's Medicare benefits could be reassigned to a practice group is the date that the practice's billing privileges went into effect. An administrative law judge for the Departmental Appeals Board (DAB) upheld the CMS contractor's determination that Westchester Surgical Associates, PLLC's (Westchester) effective date for receiving a physician's benefits was January 14, 2015, instead of the date he first began providing services there three and a half months earlier. *Westchester Surgical Associates v. CMS*, HHS Departmental Appeals Board, Civil

Remedies Division, Doc. No. C-15-3884, Dec. No. CR4503, January 12, 2016, ¶123,437.

No take-backs in administrative proceedings once a plea has been entered. A provider was properly excluded from participation in all federal health care programs following a conviction related to unlawful dispensing of a controlled substance. An administrative law judge (ALJ) for the Departmental Appeals Board (DAB) also upheld the extended length of the exclusion based on aggravating factors. *Coleman-Peterson v. Inspector General*, HHS Departmental Appeals Board, Civil Remedies Division, Doc. No. C-15-2732, Dec. No. CR4504, January 12, 2016, ¶123,438.

CMS Letters

CMS explains broadband access exceptions for providers too slow to be punished. Providers can determine if they qualify for a hardship exclusion to the broadband access objectives under the Medicare electronic health record (EHR) incentive program with the help of a CMS tip sheet. The CMS guidance explains the nature of the EHR incentive program objectives, which require patients to have online access to health information, and indicates which providers can expect to be granted a hardship exception due to slow download speeds in their area. *CMS Letter*, February 11, 2016, ¶54,179.

OIG Reports

OIG wants states accountable for Medicaid program integrity. States have not been fulfilling their obligations to spend federal money accurately and in accordance with Medicaid program rules, according to HHS Office of Inspector General (OIG) Director of Medicaid Audits John Hagg. Hagg told the House Energy and Commerce Committee Subcommittee on Health that the OIG identified specific types of expenditures incorrectly charged to enhanced federal medical assistance percentage (FMAP) categories and outlined ongoing and planned OIG reviews regarding Patient Protection and Affordable Care Act (ACA). *OIG Report*, February 5, 2016, ¶61,524.

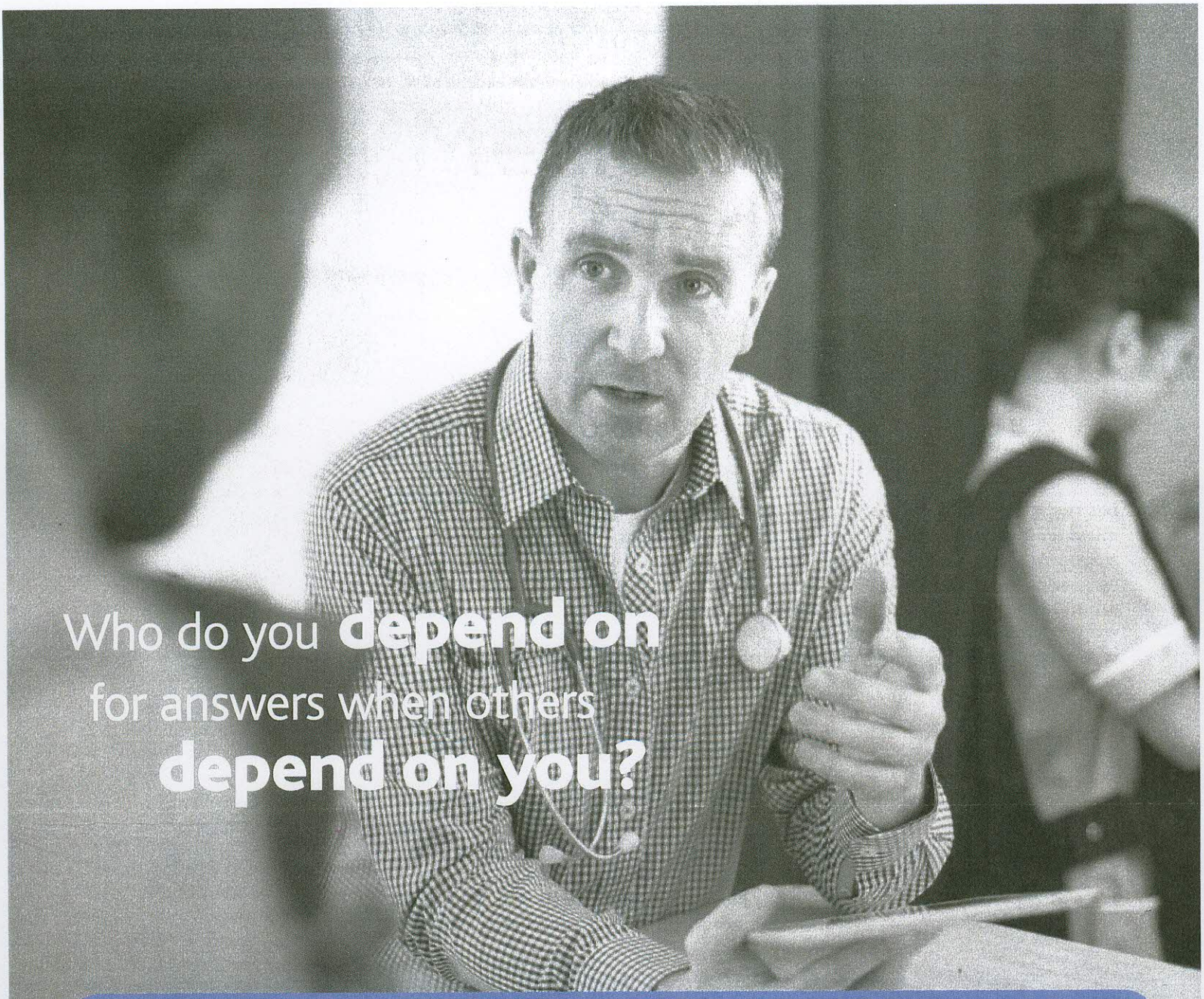
The OIG needs $419M to keep up watchdog activities. The HHS Office of Inspector General (OIG) requested $419 million for its fiscal year (FY) 2017 budget in order to oversee the administration of HHS. The budget request includes $85 million for oversight of HHS's Public Health and Human Services (PHHS) programs and the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) health insurance marketplaces. The remaining $334 million was requested to support oversight of the Medicare and Medicaid programs and related initiatives. The OIG indicated in its request that the funds would be used to further the agency's goals of protecting Medicare and Medicaid from fraud and abuse, overseeing health insurance marketplaces, and ensuring information security. *OIG Report*, February 9, 2016, ¶61,525.

Promise Hospital of Ascension incorrectly billed Medicare claims for Kwashiorkor. *OIG Report*, No. A-03-15-00007, February 1, 2016, ¶61,526.

Onsite review of Delaware Medicaid fraud control unit. *OIG Report*, No. OEI-07-15-00240, February 9, 2016, ¶61,527.

GAO Reports

Recommended changes to FMAP formula. The Government Accountability Office (GAO) reports that the formula for calculating the federal funds payable to states for their Medicaid expenditures should be changed to reflect the level of resources available to states and the effects of economic downturns. Carolyn Yocum, GAO's Director of Health Care, testified before the House Energy and Commerce Committee's Subcommittee on Health that the Federal Medical Assistance Percentage (FMAP) should be changed to: (1) reflect more accurately the level of unemployment and other income and resources available to states; and (2) adjust automatically during period when unemployment rises and state revenue falls. *GAO Report*, No. GAO-16-377T, February 10, 2016, ¶68,253.



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Oversight

CMS Cuts Lookback Period to Six Years in Final Rule on Overpayments

Medicare providers must report and repay any overpayments within 60 days of identifying them, according to a final rule released Feb. 11

Providers will be responsible for reporting and returning all overpayments identified within six years of when the overpayment was received, which differs from the 10-year period that was included in the proposed rule.

While there are no major surprises in the final rule, there are some important conceptual and operational aspects of it, Laurence Freedman, an attorney with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo PC, Washington, told Bloomberg BNA Feb. 11.

"It's very important that CMS added a critical clarification that 'identification' of an overpayment includes the '[quantification] of the amount of the overpayment'," Freedman said.

The rule (RIN 0938-AQ58, CMS-6037-F), which implements Section 6402(a) of the Affordable Care Act, will be published in the Feb. 12 Federal Register and is effective March 14.

A proposed rule was released in February 2012. The final rule was scheduled to be released in February 2015 but was delayed for a year due to its complexity.

Overpayment Identification. The Centers for Medicare & Medicaid Services's final rule requires health-care providers to repay an overpayment and to notify the federal government, the state and any "intermediary, carrier or contractor to whom the overpayment was returned in writing of the reason for the overpayment," all within 60 days of first identifying the overpayment.

According to the final rule, an overpayment identification occurs when a provider verifies an overpayment has been received, after exercising due diligence.

The CMS defined reasonable diligence as "proactive compliance activities to monitor claims and reactive investigative activities undertaken in response to receiving credible information about a potential overpayment."

The 60-day period begins after a provider has investigated an overpayment identified through a compliance program, or on the day credible information of a possible overpayment is received, assuming reasonable diligence wasn't exercised.

However, Freedman said the final rule might cause substantial confusion and disagreement over whether an overpayment should be considered identified in the absence of any reasonable diligence.

Sigh of Relief. Several aspects of the final rule are sure to please the provider community, including clarity over when the 60 days begin. "There was a collective sigh of relief this morning as the health-care industry read the CMS press release regarding the new rule," Danielle Sloane, an attorney with Bass, Berry & Sims in Nashville, told Bloomberg BNA Feb. 11.

By clarifying that overpayment identification includes both determining that a provider has received an overpayment and quantifying the amount based on reasonable diligence, the CMS is giving providers more time to thoroughly review the overpayment and make one repayment, rather than requiring them to do a rushed review or submit piecemeal repayments, Sloane said.

Overall, the final rule offers a fairly balanced and reasonable approach, Sloane said, while still setting high expectations for providers to exercise diligence and return any overpayments that are due.

For example, the CMS clarified there's no overpayment if the identified error didn't result in an increase in reimbursement, and clarified that where there is a reimbursement increase, the overpayment is only the difference between what was paid and what should have been paid if the claim had been submitted correctly, Sloane said. It wouldn't include repayment of the entire claim.

"This clarification relieves providers and suppliers concerns about having to repay entire claims for patient care services due to an identified problem without then being able submit corrected claims because of the timely filing limitations," Sloane said.

Sloane said providers and suppliers shouldn't breathe too easily, however, because the final rule sets high expectations for what constitutes reasonable diligence.

Providers and suppliers must investigate potential overpayments within six months, unless there are extraordinary circumstances, and then report and return within 60 days, Sloane said.

"I suspect that many providers and suppliers will still find that time line pretty tight, but CMS seems to leave what constitutes extraordinary circumstances pretty open ended," Sloane said.

Six-Year Lookback. While the proposed rule included a 10-year lookback period, many comment letters argued that it would be burdensome and costly for providers.

Comment letters also said a six-year lookback is a more commonly used statute of limitations under the False Claims Act, while a 10-year period is only used in certain circumstances.

The CMS agreed and said a six-year lookback would address many of the concerns held by commenters.

"I'm pleased that there is no more threat of a 10-year lookback period," Freedman said.

Though the six-year lookback period was expected, it's overly broad, Freedman said.

"CMS should have kept the reasonable four-year period under the CMS SRDP [Self Referral Disclosure

Protocol] , and should have given more weight to the administrative re-opening deadlines," Freedman said.

Freedman also said it was disappointing the CMS wants overpayments going back six years, but won't permit identification and claiming of underpayments for the same time period.

"CMS said it was outside the scope of the rulemaking, but it's not fair for CMS to have one-way rules on re-openings," Freedman said.

Lookback Burdens. While a six-year lookback period is better than 10 years, it's still an excessive amount of time for providers and suppliers to be forced to conduct audits for overpayments, Scot Hasselman, an attorney with Reed Smith in Washington, told Bloomberg BNA Feb. 11.

"Many providers and suppliers will be unable to conduct their own lookback and will have to hire third parties to do it for them. And, because limitation periods will have ended, or because record retention policies permitted earlier destruction, necessary documentation may not be available," Hasselman said.

Potential costs and resources necessary for a six-year lookback shouldn't be minimized, Hasselman said.

Providers and suppliers can take the risk of not conducting a six-year lookback, but the chance of potential liability may affect their business, particularly in connection with potential sale of transfer, Hasselman said.

BY JAMES SWANN

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The CMS final rule is at http://src.bna.com/cAP.

Data

Sale of Medicare Claims Data Could Be Boon for Quality Improvement Groups

A proposal that would pave the way for the sale of analyses of Medicare data for the first time could be a windfall for the few organizations allowed access to the data.

The Centers for Medicare & Medicaid Services recently proposed a set of rules for certain organizations that want to sell analyses of Medicare claims data. These rules, when made final, would also allow organizations given special access to Medicare claims data—known as qualified entities—to offer health-care providers and suppliers in-depth evaluations of their performance.

The agency believes the changes will bring renewed interest to the qualified entities program, which so far has produced only two public reports on Medicare spending and provider performance. Executives from several qualified entities told Bloomberg BNA they believe the changes will better help them serve health-care organizations looking to bring down the costs of delivering care.

"We're just starting to see the fruits of some of these data analysis projects."

—BRYAN SIVAK, FORMER HHS CHIEF TECHNOLOGY OFFICER

"This is a pretty big deal," Bryan Sivak, an advisor to Amino, a qualified entity, and the former chief technology officer for the Department of Health and Human Services, told Bloomberg BNA Feb. 11. "CMS historically, and for very good reasons, has kept this data private and now it's going out to third parties that can do something really interesting with it."

However, the head of one qualified entity in Washington said he's worried that some of his fellow organizations might charge exorbitant fees for their analyses.

The CMS has approved 13 qualified entities to access Medicare claims databases otherwise not released to the public and to produce public reports on trends in the federal program.

The changes, outlined in a proposed rule (81 Fed. Reg. 5,397) published Feb. 2 in the Federal Register, were required under the Medicare Access and CHIP Reauthorization Act (MACRA), a 2015 law.

Qualified Entities. All of the qualified entities except one are nonprofit organizations dedicated to improving the quality of health-care services in certain regions of the country. The only for-profit entity, California-based Amino, and one nonprofit entity have access to Medicare claims data for the entire country.

Qualified entities must meet stringent IT security requirements and go through an approval process by the CMS that can take years to complete.

The work of qualified entities, however, will become increasingly important as Medicare and commercial insurers move more providers into value-based payment arraignments, where doctors' performance on certain quality measures will determine how much they're paid, Elizabeth Mitchell, president and chief executive officer of the Network for Regional Healthcare Improvement, told Bloomberg BNA.

The changes under MACRA will allow qualified entities to furnish health-care organizations with information about the patients they serve and insights into how they fare compared to their peers, Mitchell said.

Changing Work. Nearly all the qualified entities identify themselves as quality improvement organizations, which for years have looked at claims data from commercial and public insurers for industry trends and issues, but haven't had access until recently to the same kind of Medicare claims data.

The Oregon Health Care Quality Corporation, a Portland, Ore., nonprofit and qualified entity, collects data from the state's Medicaid agency and 80 percent of the state's commercial insurers, Mylia Christensen, executive director of the group, told Bloomberg BNA.

Oregon Health looks at the total cost of health-care services in the state and recommends way to lower that cost, Christensen said. The group also offers doctors custom reports on their performance, she said.

The sale of these custom reports has been Oregon Health's main source of income, Christensen said. However, the organization can't currently include the Medi-