



June 22, 2015

The Honorable Orrin G. Hatch, Chair  
The Honorable Ron Wyden, Ranking Member  
The Honorable Johnny Isakson  
The Honorable Mark Warner  
Committee on Finance  
United States Senate  
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

On behalf of LeadingAge, I am writing in strong support of the working group the Finance Committee has formed to examine the ways in which services for people with chronic health conditions can be improved.

The mission of LeadingAge is to expand the world of possibilities for aging. Our membership has a service footprint of 4.5 million people. Our community of 6,000 members provides the full range of services to elders and people with disabilities, including nursing home care, home- and community-based services, affordable housing, assisted living and continuing care retirement communities.

Most of the people our members serve have at least one chronic health condition, and the majority of the population has multiple co-morbid conditions. Our members constantly face the issues noted in your letter – lack of coordination in services, problems with medication management, the enormous potential of technology to improve quality of care and quality of life, the special needs of people living in rural and frontier areas, and encouraging people to take a more active role in managing their conditions. So we appreciate the opportunity to work with you on solutions.

1. Post-Acute Care and Long-term Services and Supports must be included in any efforts to improve chronic care coordination

Legislation that focuses on health care coordination seems to start and stop at the doctor's office and hospital bed, but the real life experience of patients crosses many other boundaries, from home to nursing home, and disciplines, from health care to transportation to meals. The financing mechanisms to ensure adequate and quality care coordination are not limited to Medicare but must include programs traditionally funded through Medicaid or paid privately or delivered voluntarily, and housing. Long-Term Services and Supports (LTSS) are often add-ons to legislation, even to the pilot projects under the Affordable Care Act.

Providers of post-acute care (PAC) and long-term services and supports (LTSS) have expertise in managing chronic care, but they have been left on the fringes of projects to demonstrate new and better ways of serving people with chronic conditions. ACOs and bundled plans under the

ACA are centered on acute care providers, and even when these models include LTSS and PAC providers, they are seen as an adjunct rather than a partner in improving care and reducing health care costs.

Solution: Include PAC and LTSS providers as equal partners at the beginning of the planning and implementation process for coordinating chronic care. Include providers of Medicaid services and low income housing to address the needs of dual eligible beneficiaries.

2. Coordinating care for persons with chronic conditions depends on social supports as well as medical care

The greatest weakness of traditional Medicare in serving people with chronic conditions is that coverage is limited to rigidly-defined medical services and focuses on Medicare. The data is quite clear that the highest cost seniors are dual-eligibles. These seniors have considerably different needs than seniors who are not poor enough to meet state Medicaid eligibility income thresholds.<sup>1</sup> These needs include access to social services, care coordinators, and housing as well as health care.

Traditional Medicare coverage focuses on hospital care, doctor visits and skilled nursing. Better coverage of prescription medication is a relatively recent addition to Medicare.

But people with chronic conditions need a variety of other services in order to successfully manage their conditions. Medicare coverage of a doctor visit is less useful if the beneficiary does not have transportation to reach the doctor's office. Medicare will cover a beneficiary's prescription drugs but will not pay for someone to help the beneficiary manage the myriad intricacies of dosages and interactions with food and other substances.

Medicare will pay for hip surgery and post-acute rehabilitation, but not for the fall prevention strategies that can be provided in the home before the hip fracture, such as a shower seat or grab bar that will reduce the risk of the fall from occurring.

This traditional approach is penny-wise and pound foolish. Medicare will pay tens of thousands of dollars to cover a hospital stay that could have been prevented by far less expensive, non-medical interventions.

Your letter cites the success Medicare Advantage plans have achieved in disease management and care coordination. In addition, these plans often offer coverage of non-medical services that people with chronic conditions need in order to manage successfully. To control costs, these plans may take a holistic, person-centered view of the services each of their members needs. This approach should be taken in the Medicare program generally to better serve people with chronic conditions.

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<sup>1</sup> *A Picture of Housing & Health*, <http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.pdf> ; Semuels, Living, and Dying, at Home, *The Atlantic* (<http://www.theatlantic.com/business/archive/2015/05/living-and-dying-at-home/391871/>).

As discussed in greater detail at Point 4, below, affordable housing with supportive services must be part of the solution as well. Research shows that when frail people have decent housing adapted to their physical needs, their chronic conditions can be managed more cost-effectively. Affordable housing with supportive services can help to prevent expensive trips to the emergency room and other high-cost settings.<sup>2</sup>

Solution: We urge the working group to take a comprehensive view of chronic care services and consider the social supports that people with these conditions need in order to successfully manage them. Revising Medicare payment systems for medical care providers, while important, will not reach the root of the issues entailed in serving people with chronic conditions. Addressing the need for chronic care services must include addressing functional limitations, not just disease, and socio-economic conditions. We urge Congress to pass the Community Based Independence for Seniors Act (S. 704). This bipartisan bill helps prevent the need for nursing home care by establishing a new Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program that provides for home and community-based services, such as adult day services, transportation and meals for low-income, Medicare-only beneficiaries who need help with 2 or more activities of daily living. The program would operate in up to five states by Medicare Advantage plans that have experience caring for this frail population and it would generate evidence to support an alternative payment methodology that could produce savings for both states and the federal government

### 3. Home- and community-based services coverage must improve

Although progress has been made under the Affordable Care Act and other legislative and regulatory efforts to broaden improve home- and community-based services, more needs to be done. Medicare covers only post-acute services for a limited time period. Paying out of pocket is often unaffordable.<sup>3</sup> Medicaid coverage is available only on an income eligibility basis and many states have waiting lists. And the Older Americans Act is both unauthorized and grossly underfunded. There are effectively no private resources available to subsidize HCBS outside of the federal and state programs. The burden thus falls on families, especially daughters, to provide or finance care and services to family members with functional limitations and chronic conditions.

People with chronic conditions need care and services at home, not in a hospital or doctor's office.

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<sup>2</sup> See, e.g., Coleman EA, Boulton C. Improving the quality of care for persons with complex care needs. *J Am Geriatr Soc* 2003;51:556-7; <http://www.urban.org/research/publication/housing-platform-improving-outcomes-older-renters>; Gawande, The Hotspotters: Can we lower medical costs by giving the neediest patients better care?, *The New Yorker*, January 24, 2011; Gawande, *Being Mortal: Medicine and What Matters in the End*, Chapter 5, A Better Life (Henry Holt & Company, 2014); Sanders, Affordable Senior Housing Plus Services Program Slows Growth in Medicare Costs, [http://www.leadingage.org/Affordable\\_Senior\\_Housing\\_Plus\\_Services\\_Program\\_Slows\\_Growth\\_in\\_Medicare\\_Costs.aspx](http://www.leadingage.org/Affordable_Senior_Housing_Plus_Services_Program_Slows_Growth_in_Medicare_Costs.aspx).

<sup>3</sup> For a good general discussion, see Commission on Long Term Care, Report to the Congress (9/30/2014).

Solution: we urge the working group to examine ways to better integrate and finance home- and community-based services. . We encourage Congress to pass the [PACE Innovation Act \(S. 1362\)](#). This legislation would allow PACE to expand their service to persons ages 21-55 with disabilities. Currently individuals must be 55 or older with a skilled need. LeadingAge also urges Congress to pass the [Older Americans Act Reauthorization Act of 2015](#) (S. 192). This legislation would improve Aging and Disability Resource Centers coordination with area agencies on aging and other community-based entities in disseminating information regarding available home and community-based services for individuals who are at risk for, or currently residing in, institutional settings. The bill would also promote the delivery of evidence-based programs, such as falls-prevention and chronic disease self-management programs.

4. Low-income housing with services should be viewed as an integral and critical platform for coordinating care and services.

Affordable housing properties linked with health and supportive services provides an option for meeting the varied needs of lower-income seniors while also helping address multiple public policy priorities. Dual-eligible, low income seniors are the biggest users of health and long-term care services; housing that offers personal assistance enhances access to necessary services and supports, helping individuals to better manage their conditions and coordinate their care needs.

Housing Plus Services models focus on low-income seniors in subsidized housing, building on the existing infrastructure of housing, health and community service networks. With the concentration of high-risk, high-cost residents, many of whom are dually eligible for Medicare and Medicaid, senior housing offers an economy of scale that can increase delivery efficiencies for providers and affordability for seniors. Seniors gain easy access to services, which encourages greater utilization and follow-through. These settings offer a more regular staff presence for residents. Onsite staff members can help build knowledge of resident needs, abilities and resources; a sense of trust among residents, which encourages better use of services; and early recognition of potential issues before they become costly crises. Finally and perhaps most importantly, housing that provides social services helps preserve seniors' autonomy and independence, which in turn helps residents meet the challenging goal to age in place.

The Support and Services at Home (SASH) program in Vermont is an example of how the intersection of housing, services and health care delivery is slowing the growth of annual total Medicare expenditures for program participants, according to early findings from a 3-year evaluation conducted by the LeadingAge Center for Applied Research (CFAR) and RTI International for the Office of the Assistant for Planning and Evaluation (ASPE) at HHS. The growth of annual total Medicare expenditures for early SASH participants was \$1,756 to \$2,197 lower than the growth in Medicare expenditures for beneficiaries in 2 comparison groups<sup>4</sup>.

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<sup>4</sup> ASPE, Support and Services at Home (SASH) Evaluation, First Annual Report (Sept. 2014), <http://aspe.hhs.gov/daltcp/reports/2014/sash1.pdf>

SASH is based in affordable senior housing; SASH teams consist of housing-based care coordinators and wellness nurses that work with dedicated representatives of community-based service agencies to support participating affordable housing residents address and coordinate their health and social service needs. Most importantly, SASH was integrated into Vermont's Blueprint for Health in 2011, a statewide health reform effort designed to deliver comprehensive, coordinated care that improves health outcomes and lower costs. As a partner in Vermont's Medicare Multipayer-Advanced Primary Care Practice demonstration, SASH provided focused in-home support and services to specific participants.

Solution: Although low-income housing is not within the purview of the Senate Finance Committee, the important role housing plays in supporting the health and safety of seniors cannot be ignored. The SASH demonstration is only one of the examples of the important role that low income housing for seniors can play in improving lives and reducing costs.

We urge the committee to include the Banking, Housing, and Urban Affairs Committee, which has authority over HUD programs, as you develop further legislation on coordinating chronic care. Both HUD and HHS have met over the past decade to address this issue, and it is essential that the nexus between housing and care coordination in the Medicare/Medicaid program be specifically addressed in legislation to break down silos between these programs.<sup>5</sup>

5. Chronic care coordination cannot be effectively implemented without also understanding and ultimately addressing the need for financing solutions to providing long-term services and supports.

LTSS forms the backbone of coordinating health care for persons with chronic conditions, as noted above. Medicare and private health insurance do not pay for LTSS. Rather, LTSS is either paid privately, or volunteered, or through the Medicaid program. LeadingAge, the broader aging services and consumer community, and the disability community have long argued for a national conversation, if not solution, to paying for LTSS. And, if we want people with functional limitations to remain in their community, we must address how to pay for services and supports.

Unfortunately, the Commission on Long Term Care established by Congress in 2012 to address this issue, like the Medicaid Commission of 2005 before it, failed to come to agreement on how to pay for LTSS in the future. However, the issue, and the concomitant cost to society and government, does not go away just because solutions are difficult. See, LeadingAge PATHWAYS: A Framework for Addressing Americans' Financial Risk for Long-Term Services and Supports. (Pathways Final Report Zmag.pdf)

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<sup>5</sup> See, e.g., Magen, How Can Housing Providers Get Under the Health Care Tent? [http://www.leadingage.org/How\\_Can\\_Housing\\_Providers\\_Get\\_Under\\_the\\_Health\\_Care\\_Tent.aspx](http://www.leadingage.org/How_Can_Housing_Providers_Get_Under_the_Health_Care_Tent.aspx); LeadingAge, Housing Plus Services: Implications for Public Policy, [http://www.leadingage.org/Housing\\_Plus\\_Services\\_Implications\\_for\\_Public\\_Policy.aspx](http://www.leadingage.org/Housing_Plus_Services_Implications_for_Public_Policy.aspx)

Solution: Recognizing that there is no one easy solution to financing LTSS, LeadingAge nonetheless urges this Committee to include congressional commitment to addressing financing in its recommendations for improving chronic care coordination.

Turning to the specific questions identified in your letter:

- A. Improvements to Medicare Advantage for patients living with multiple chronic conditions.
  - a. Medicare Advantage needs meaningful quality measures that incorporate HCBS quality measures.
  - b. It is critical to identify which wellness initiatives work for beneficiaries who are in poor health.
  - c. Data on quality and outcomes needs to be public so that Congress, CMS and the public can understand where there are benefits and where there are limits to MA.
  
- B. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures.
  - a. MedPAC Commissioner Mark Miller, in his May 2015 testimony before this Committee noted that “in the longer run, Medicare must move away from FFS and toward models that require plans and providers to take financial responsibility for achieving high-quality outcomes while coordinating a beneficiary’s full spectrum of care.” He identified both ACOs and MA plans as having potential to achieve these goals but noted, and we support his concerns, “both could benefit from policies to improve their willingness and ability to care for the sickest beneficiaries.”
  - b. The current APMs and ACOs are too acute-care dominated. It is critical that post-acute care providers and LTSS providers have a meaningful presence and seat at the table as models are being developed, implemented and evaluated. PAC and LTSS providers have extensive expertise in managing chronic care, but they have been left to the fringes of projects intended to demonstrate new and better ways of serving people with chronic conditions. ACOs and bundled plans under the ACA are centered on acute care providers, and even when these models include LTSS and PAC providers, they are seen as an adjunct rather than a partner in improving care and reducing health care costs.
  - c. Independence at Home (IAH) is a model currently being studied by CMS, which holds promise to coordinate care and reduce health costs of Medicare beneficiaries with two or more chronic diseases by working across provider types (personal doctor, home health, technology). We strongly recommend continuing and expanding the IAH pilot program and support S. 971, Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015, which continues and expands the IAH pilot program.

- C. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.
- a. One simple improvement would be to mandate that the originating or referring entity (e.g., hospital) include the patient’s medical records when the patient is discharged (e.g., to a SNF). Our SNF members are far-too-frequently handed patients with no records (e.g., in the evening), and must guess at the patient’s condition (including whether they were actually an in-patient and eligible for SNF benefits or under observation and not), find a doctor to prescribe needed medications, and otherwise figure out the needs of the patient.
  - b. Another simple improvement would be to require the referring entity to provide the patient with medically necessary prescription medications to bridge the transition to home or SNF, rather than sending the patient with no prescriptions.
  - c. Amend the IMPACT Act to require that hospitals collect the same kind of data on patients as is required for PACs (SNFs, home health, hospice). It is unrealistic to provide coordinated care when the biggest player is not required to understand the patient’s socio-economic risk factors. This necessitates not only a technical mandate but also a change in perspective for the acute provider community – it’s not just about the meds, it’s about the person. It’s not just SNFs and home health and HCBS that need to provide person-centered care; it’s the acute care system, too.
  - d. LTSS and PAC providers must be integrated from the beginning in technology initiatives and federal funding opportunities. As critical partners with the acute care system, it is essential that PAC and LTSS providers are part of the financing and development of electronic health records, personal health records and telehealth and telemedicine initiatives. Federal initiatives should not perpetuate the current health care silos.
- D. The effective use, coordination, and cost of prescription drugs.
- a. Appropriate transitions of care must include review of and access to needed medications when transferring from one setting of care to another. Failure to review for unnecessary or inappropriate drugs, as well as failure to provide needed drugs, creates gaps in care and significant risk for adverse outcomes and rehospitalization.
  - b. Another failing of the current system, contributing to the lack of coordination between the primary care physician and the SNF setting, is the lack of recognition that SNFs are not hospitals and most do not have on-site pharmacies. When a SNF resident needs a prescription medication, e.g., to address pain, the SNF must contact the physician, the physician must determine whether to prescribe medications, and then provide a written prescription to the off-site neighborhood pharmacy. On too many occasions, the time-lag between need and delivery of relief is too long because the licensed nurse in the SNF cannot call in the prescription orally (neither the SNF nor the licensed nurse is the agent of the physician). The SNF and patient community has for many years been trying to

fix this problem through legislation that allows a professional at the SNF to be designated the agent of the resident’s physician. We urge the Committee to address this issue.

E. Ideas to effectively use or improve the use of telehealth and remote monitoring technology

- a. We recommend national demonstrations of innovative care models that are led by, or truly emphasize, long-term and post-acute care providers who primarily serve the chronically ill population (rather than acute care providers) to:
  - i. Conduct cost-effectiveness evaluation of efficacy-proven technologies, including telehealth, RPM, EHRs and HIE (which are proven in the VA System) under new innovative payment models for LTPAC free from current CMS restrictions.
  - ii. Payment model should probably be developed in partnership between payers (Medicare, Medicaid, even private health and long-term care insurance) and care provider with experience in these technologies and operational models, to ensure proper alignment of incentives and avoid past failures.
  - iii. Evaluations should also be designed in partnership between participating payers, providers and the independent evaluation researchers to ensure that the evaluation methodology is a good match with the models.
  - iv. Demonstrations need to be relatively large scale, not small pilots, to get meaningful results.
  - v. Successful demonstrations should turn into longer-term programs.
- b. We recommend that HHS grant all Medicare Shared Savings ACOs, including those participating in all two-sided performance-based risk tracks, a waiver from the 1834(m) restrictions for any FFS patients cared for by an ACO, including those with complex chronic conditions.
  - i. Such a waiver should:
    - 1. Eliminate the restriction on location (originating site) and presence of a health professional for receipt of telehealth delivered evaluation and management services, to include home-based remote care management and remote patient monitoring, and non-rural areas
    - 2. Eliminate the stipulation of live voice and video, to ensure coverage of store-and-forward remote patient monitoring and telephone-based remote care management and coordination
    - 3. Expand the scope of distant site providers eligible for reimbursement to include not only physicians, physician assistants, and hospitals, but also nurse practitioner, home health and hospice agencies, nurses, and care managers.
  - ii. Section 1834(m) of the Social Security Act restricts Medicare reimbursement to a limited number of Medicare Part B services furnished through particular telecommunications systems to only those beneficiaries

able to reach an “originating site” located in a rural Health Professional Shortage area or a county outside of a Metropolitan Statistical Area (MSA). Specifically, “originating sites” only include physician offices, hospitals, critical access hospitals, skilled nursing facilities, and Federally Qualified Health Centers.

- iii. Currently, these 1834(m) restrictions create a disincentive for the vast majority of ACO providers—many of whom are located in urban and suburban areas—to appropriately use this type of technology, and exclude a broad segment of Medicare beneficiaries from being able to access the benefits of telehealth. ACOs that do not receive reimbursement for telehealth services under Medicare Fee for Service (FFS) are faced with the difficult decision of assuming financial risk by providing the care for free. This is particularly true for smaller or physician-led ACOs, where assuming such risk is not financially feasible.
- iv. Since the goal of the alternative payment models, including Shared Savings ACOs, is to treat patients in the most efficient and comprehensive programs, the addition of telehealth as part of the care plan will tie closely to the goals. Telehealth reimbursement should be allowed as a tool to achieve reduced hospital readmissions, bed days and emergency room visits while providing care in the least restrictive and costly settings.

F. Strategies to increase chronic care coordination in rural and frontier areas:

- a. HCBS can be more expensive in rural areas because of the distances involved. Cost for providing care and services must be viewed as an investment in preventing higher-cost interventions like hospitalization. Essential reforms will not always be budget-neutral.
- b. There also is an increased need for non-medical services – transportation, meals on wheels, access to services – that must be met to ensure that care can be coordinated across settings.
- c. In addition, the federal government must do more to encourage the use of technology to improve care and care coordination. While we understand that focusing on interoperable EHR for doctors and hospitals is essential, failing to include PAC and HCBS providers significantly limits the ability to coordinate care across settings and in the most effective locations. By not including the non-acute care sector at the beginning of the process, we will not be able to integrate care coordination seamlessly.
  - i. Congress should pass the Fostering Independence Through Technology Act (FITT), which provides demonstration programs for the use of home health technology in rural and underserved areas;
  - ii. Another good model that uses technology to monitor health in a long-term care and senior housing setting is the “Living Well at Home” program developed by the Evangelical Lutheran Good Samaritan Society, which uses personal monitoring technology to monitor and help seniors manage their health care.

[http://www.leadingage.org/uploadedFiles/Content/About/CAST/Pilot\\_Projects/Evangelical\\_Lutheran\\_Good\\_Samaritan\\_Society\\_Case\\_Study.pdf](http://www.leadingage.org/uploadedFiles/Content/About/CAST/Pilot_Projects/Evangelical_Lutheran_Good_Samaritan_Society_Case_Study.pdf)

- iii. Another example is the virtual adult day program instituted by Self Help Community Services in New York to link home-bound seniors with Self Help's adult day program and senior center. While this program takes place in New York City, our members' experience is that urban poor and rural poor experience similar levels of isolation and disconnection.

[http://www.leadingage.org/uploadedFiles/Content/About/CAST/Pilot\\_Projects/Selfhelp\\_Community\\_Services\\_Case\\_Study.pdf](http://www.leadingage.org/uploadedFiles/Content/About/CAST/Pilot_Projects/Selfhelp_Community_Services_Case_Study.pdf)

G. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

- a. We strongly support efforts to expand and enhance person-centered care, defined as care that reflects the individual's goals, values and preferences, and within the context of understanding their personal social situations. People who experience chronic disease or disability are the best experts on living with their condition; and for persons who lack cognitive capability; their caregivers perform this expert role. Self-direction, meaningful involvement in decision-making, person-centeredness and individual empowerment are key tools to sustaining and improving health. When the individual and/or their caregiver is in the "driver's seat", they can work with their health care and service providers to develop a plan that has a much greater chance of success than a plan that fails to incorporate their perspectives and values. Underpinning the policy for chronic care coordination should be a commitment to and requirement for patient involvement at the individual treatment and health provider level.
- b. When the individual relies on a family or other caregiver, it is critical that the caregiver receive adequate education, training, and supports.
  - i. Supports: caregivers traverse the entire system with the individual – from doctor visits to hospitals/outpatient centers to post-acute care back to home. That caregiving is physically, psychologically and financially exhausting has been well-documented. We strongly recommend including adequate financing for family respite programs in any chronic care legislation.
  - ii. Education and training: caregivers need to have education in the health care conditions and appropriate interventions to improve both health and functioning of the person cared for. The system relies extensively on these, usually unpaid, individuals who have no particular expertise but nonetheless are expected to provide significant health care (including medication management, basic nursing, nutrition, etc.) with no training. We strongly recommend including adequate training for caregivers in any chronic care legislation

H. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

- a. At the policy level, it is essential that LTSS and PAC providers have a “seat at the table.” We are already developing and managing models of care and services that provide significant benefit for persons with chronic health care conditions, and these models need to be incorporated into any chronic care legislative model. Creating a seamless system will not happen if PAC and LTSS providers are excluded from or considered adjunct to the chronic care model.
- b. It is important to include “functional limitations” when addressing care coordination; the inability to perform activities of daily living has an adverse impact on the person’s ability to manage their chronic conditions and improve or maintain their health. In addition, caregivers, whether family or other, play a critical role when the individual has ADL limitations, and this role is essential to recognize when addressing chronic care.
- c. Housing is a platform for providing services to Medicare beneficiaries. Senior housing for low-income seniors that includes meaningful service delivery may become a significant model for reducing Medicare (and possibly Medicaid) costs, as such evidence-based pilots as the SASH program and the research project\_\_\_\_ (CFAR/ASPE study) have shown.
- d. It is vital to focus on dual-eligible persons. The data clearly show that these individuals have the most significant health care conditions and are least likely to have access to the social supports that improve health care (transportation to doctors, medication management, simple technological assists, adequate housing, good caregivers). The linkage between Medicare and Medicaid cannot be ignored; the importance of adequately funded Medicaid programs is essential to improving the health outcomes for dual eligibles, and the ability of the Medicare and Medicaid programs to work together is essential.

LeadingAge commends the Committee for making caring for persons with chronic health conditions a priority; this is not just an issue for the primary care health care community but also providers and recipients of long-term care and supportive services and housing. We thank you for this opportunity to share our views and look forward to working with you as you develop legislation and policies to improve the lives of the people we serve.

Please contact me if you have any questions or if we can be of further assistance.

Sincerely yours,

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