AHCA® AMERICAN HEALTH CARE ASSOCIATION
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January 26, 2016

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
104 Hart Senate Office Building
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The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Isakson
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
75 Russell Senate Office Building
Washington, DC 20510

Senators Hatch, Wyden, Isakson and Warner,

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) is pleased to submit comments on the December 2015 Bipartisan Chronic Care Working Group Policy Options Document. Through our representation of more than a million skilled nursing center beds, approximately 200,000 assisted living beds, and close to 5,000 intellectual and developmental disabilities (ID/DD) beds, AHCA/NCAL has extensive experience with chronic conditions.

The Association also had the opportunity to study many models that served as foundations for the proposed December 2015 policy options. Association members, in addition to delivering care to the relevant population on a daily basis, also participated in many past demonstrations and programs upon which the proposed policy options are based.

Below, we provide an overview of the Association's perspective on chronic condition care management approaches as well as option-by-option comments incorporating our view of historical, foundational approaches.

Background on Chronic Care Models

The Centers for Disease Control (CDC) found that "[t]wenty-six percent of adults have [multiple chronic conditions] MCC; the prevalence of MCC has increased from 21.8% in 2001 to 26.0% in 2010. The prevalence of MCC significantly increased with age …."[1] Therefore, post-acute and long-term care providers, who typically serve an older population, have experienced a significant increase in the proportion of patients and

[1] Ward, B, Shillier, J. Centers for Disease Control. Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey, 2010. CDC 2013.

residents with multiple chronic conditions. We considered the proposed policy options through the lens of our historical experience as well as recent experiences with a rapidly increasing number of patients and residents with multiple conditions.

Medicare research on high cost users consistently reveals several key features. First, roughly five percent of the Medicare population consumes nearly half of the Medicare budget.[2] Second, research shows that functional disability predicts higher medical costs. Finally, although some patients develop a single catastrophic illness from which they fully recover or die, most patients with multiple chronic conditions have a high likelihood of being persistent high-cost users (e.g., resource use intensive) over a period of several years.[3]

We believe it essential to distinguish this subgroup of very ill individuals from the much larger population of functional elders with one or two chronic diseases. A disease management program may attend to the needs typical of the less ill population. The very high-cost beneficiaries, those with multiple chronic conditions and dependence upon others for care, however, are a very different population.[4]

Additionally, multiple chronic conditions are further complicated by psychological stress, financial hardship, social isolation, and legal challenges. Any models designed for this population must go beyond addressing not only a single condition but rather a web of interrelated challenges based on multiple, interactive chronic conditions and strongly related non-medical challenges.

Recent research also found differences between younger persons with disabilities and older adults with disabilities regarding support setting. Specifically, older adults tend to prefer congregate settings more than younger adults with disabilities.[5] Any initiative for persons with multiple chronic conditions should take into consideration differences between younger and older adults with disabilities both in terms of preferred care settings as well as the differing types of expertise needed to deliver such care. Skilled nursing centers and assisted living centers have substantial expertise in delivering and coordinating care for older adults with multiple chronic conditions. Finally, affordable accessible housing remains a challenge for all persons with disabilities. For low-income older adults with multiple chronic conditions, assisted living and skilled nursing centers often are a critical source of shelter when other options are unavailable.

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[2] Wennberg, JE, Fisher, ES, Goodman, DC, et al. Tracking the Care of Patients with Severe Chronic Illness. The Dartmouth Atlas of Health Care 2014.

[3] MedPAC. Report to Congress, June 2015.

[4] In today's quality and value-based purchasing vernacular, "costs" also could be characterized as "resource use." For example, MACRA and IMPACT Act include both quality and resource use measures. The latter focus on Medicare spending per beneficiary in one metric area.

[5] Robinson, J, Shugrue, N, et al. Long-Term Services and Supports Planning for the Future: Implications from a Statewide Survey of Baby Boomers and Older Adults. The Gerontologist, doi 10.1093/geront/gnt094.

Evolution of Chronic Care Models

The U.S. population's aging demography, modern medicine's success in preventing death from acute illness, and the growing prevalence of severe chronic illness have motivated attempts to redesign health care for high-risk elders for a number of years. In past 20 years, the United States has explored several alternative models of care delivery and financing. These include social health maintenance organizations (S/HMO), Program for All-Inclusive Care of the Elderly (PACE), Medicare Care Coordination (MCC) demo, Special Needs Plans (SNPs), Chronic Care Model (CCM), Medicare Health Support (MHS), Disease Management (DM) and the Advanced Medical Home (AMH). Below we provide observations on the performance of these models and highlight how these previous attempts at delivering care to persons with chronic conditions might impact future policy development.

- ***S/HMO*** – Research on S/HMO indicated they "have not proven they are worth the substantial additional cost to Medicare."[6] In 2001, the government phased out the S/HMO program into the Medicare-Plus-Choice managed care program and reduced their payments. Later, many of the former S/HMOs became Medicare Advantage Special Needs Plans (see below). The S/HMOs ultimately phased down because the beneficiaries they were designed to attract and their related chronic care costs made the organizations too costly. **AHCA/NCAL recommends that any policy option based on upon a plan model address the challenges faced by S/HMOs and more modern models (see below). Of critical importance are: 1) accurate risk adjustment; 2) plan transparency via granular, publicly available encounter data; and 3) plan accountability via functional outcome measures.**

- ***PACE*** – While research on PACE indicates PACE is virtually the only integrated model (i.e., Medicare and Medicaid) to demonstrate improved quality for persons with chronic conditions, the model has been slow to expand. Reasons for slow adoption of the PACE model include strict clinical and income entry criteria and reluctance of health systems to set aside escrow funds needed for the financial risk model. In the final analysis, although PACE demonstrated improved quality, the program serves only a small number of frail elders and did not demonstrate overall cost savings for Medicare and Medicaid the Work Group likely would want from this exercise.[7] [8] **AHCA/NCAL suggests that any PACE-like model would need to address questions: 1) cost effectiveness; and 2) challenges with the geographic restrictions and centralization requirements. Such issues could spill over into similar geographically defined models (e.g., Accountable Care Organizations).**

- ***CCM –*** CCM originated with research indicating that when caring for patients with chronic illnesses, clinicians often do not follow evidence-based guidelines or provide care coordination and patients typically are not trained to manage their own illnesses. A Robert Wood Johnson Foundation (RWJF) report on CCM notes challenges with changing the behaviors of physicians and health organizations and that execution of CCM

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[6] Wooldridge J, Brown R, Foster, L, et al. Social Health Maintenance Organizations: Transition in Medicare + Choice. Princeton, NJ: Mathematica Policy Research, Inc.; 2001.

[7] Gross, GL, Temkin-Greener H, Kunitz S et al. The Growing Pains of Integrated Health care for the Elderly: Lessons from the Expansion of PACE. Milbank Q. 2004.

[8] Mukamel DB, Temkin-Greer H, Delavan R. et al. Team Performance and Risk-Adjusted Health Outcomes in the Program of All-Inclusive Care for the Elderly (PACE). The Gerontologist 2006.

principles requires a substantial increase in provider time and expenses.[9] **AHCA/NCAL believes any proposal should require practitioners and providers of non-acute services to follow evidence-based practices and deliver, or cooperate, in care coordination activities outside of their scope of practice.**

- ***SNPs –*** SNP research continues to raise questions about the clinical or economic benefits of the plans and continues infuse uncertainty into continuation of the authority.[10] Of the three types: chronic condition, duals, and institutional SNPs; chronic condition SNPs appear to have the weakest evidence of improve quality or cost outcomes. In fact, MedPAC recommended that authority for chronic conditions SNPs be allowed to expire due to questionable outcomes.[11] A possible weakness of SNPs is the breadth of inclusion criteria. Specifically, the plans may not focus on high-cost beneficiaries with multiple chronic illnesses and disabilities because of cost and coordination issues. Several decades of health service research show that targeting the highest-risk and highest-cost subgroups is the key to savings. **AHCA recommends that any SNP-based option be carefully crafted to address ongoing questions about C-SNP efficacy and include rigorous performance monitoring via outcome measures (see S/HMO comments above, as well).**

- ***MHS*** – Under this model, elders with one or more chronic illness were assigned to large organizations, primarily DM organizations. These organizations were held responsible for clinical and economic outcomes. Most MHS organizations did not provide in-person medical care and focused on phone-based DM. The vast majority of the 20,000 participants were assigned to DM organizations while under the care of physicians not engaged in the initiative. MHS organizations had to recruit participation. MHS was terminated five years after its launch due to lack of cost savings evidence.[12] **AHCA/NCAL believes any multiple chronic condition care model must include regular, in-person interactions with patients and their caregivers much as those delivered in post-acute and long term care settings.**

- ***DM and AMH*** – DM programs and medical homes typically are not designed to coordinate the array of medical and social supports needed by persons with multiple chronic conditions. These programs and models also do not have targeted strategies supporting high cost Medicare beneficiaries. **AHCA/NCAL believes any model must be broad enough to support the array of acute and non-medical care needs experienced by persons with multiple chronic conditions**.

In sum, the most successful models of care for elders with multiple chronic conditions must address more than general medical care and must have the capacity to coordinate care across several conditions as well as address social needs. Care is also more effective when tailored to an individual. The federal government already has an array of Medicare changes and demonstrations underway which fundamentally will impact provider capacity and behavior. This comprehensive, targeted care is most needed in the United

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[9] Robert Wood Johnson Foundation. Improving Chronic Illness Care: The Chronic Care Model.
[10] Verdier, J, Gold, M. Mathematica Policy Institute for Kaiser Family Foundation. Do We Know if Special Needs Plans are Special? 2008.
[11] MedPAC. Report to Congress. March 2013.
[12] Abelson R, Medicare Finds Out How Hard It Is To Save Money. New York Times. 2008

States during the period when the number of 85-plus elders will increase the most precipitously,

As we indicated in our initial letter, we strongly recommend the Work Group carefully consider unintended consequences of the proposed policy options. Such unexpected impacts could interact with existing demonstrations or payment systems that already are moving from traditional fee-for-service to other methods of payment and negatively affect patient access. While we appreciate the efforts of CMS to modernize and innovate, the Association is concerned about the number and pace of changes. We laud the Work Group's position on transparency and thoughtful policy development in the face of the array of changes already underway in an already fragile post-acute and long term care provider sector.

Policy Option Comments

In the section below, we offer comments on selected policy options. In some instances, we offer integrated comments for more than one policy option.

1. ***High Quality in the Home*** – AHCA/NCAL recognizes the value of the Independence at Home (IAH) demonstration and views the model as one which would be complemented by closer ties to post-acute care and an increased emphasis on rehabilitative and maintenance therapy (e.g., ***Jimmo***) to reduce hospital admissions and prevent further declines associated with functional disability (see comments above on functional disability among this population). In terms of the modifications to IAH, specifically, AHCA/NCAL suggests that the Work Group contemplate a waiver of the three-day stay to allow IAH demonstration sites to directly admit IAH participants to SNFs and avoid unnecessary hospital stays. Physicians groups participating in IAH would have strong incentives only to refer a patient to SNF services because of the savings target to which they are held accountable. Furthermore, AHCA/NCAL suggests offering guidance to IAH groups on how to effectively partner with skilled nursing facilities and private pay occupants or Medicare Part B beneficiaries residing in assisted living facilities. Physician visits in skilled nursing facilities during a post-acute care stay as well as visits to assisted living residences would greatly improve patient and resident continuity of care, respectively, and would improve coordination among IAH clinicians and post-acute and long-term care setting-based clinicians.

   Finally, we suggest that function (mobility and self-care) be a baseline and periodic measure of the success of the program. The maintenance of function, as noted in our comments on functional disability, is the key determinant of whether a person with chronic health conditions requires institutional care. The CARE item set has been validated by recent CMS demonstration projects in acute, post-acute care, and outpatient therapy settings. For this high-risk population, the CARE mobility and self-care items could be utilized in clinician assessments to identify success at maintaining function as well as for identifying individuals at risk for institutionalization that could benefit from interventions, including environmental modifications, durable medical equipment, and physical and occupational therapy services.

2. **Advancing Team-Based Care** – As discussed in the background section, above, plan-based models have been unable to demonstrate the desired quality and cost outcomes. PACE is the one exception with improved quality outcomes but with little evidence of savings.

    a. *Medicare Advantage* – We respectfully highlight an array of challenges associated with Medicare Advantage plans, both SNP and "regular" MA, and urge the Work Group to consider enhanced requirements for plan reporting as well as a formal evaluation for such demonstrations to ensure a comprehensive understanding of how any changes in benefit structure and care delivery impact patients with multiple complex conditions and the Medicare program. In addition, MA encounter data should be made available to the public so that researchers and policymakers can compare the current program with any demonstration programs. Such information will be critical before making any changes nationwide and permanent.

    A recent survey of analytic staff in federal agencies and other Medicare experts indicates that researcher access to encounter data would better illuminate if and how MA plans coordinate care and whether they are more efficient than traditional fee-for-service Medicare.[13] Available evidence seeks to highlight differences in utilization and quality among MA enrollees when compared to FFS beneficiaries; however, the studies fall short on many desirable dimensions, including lack of timely data, and study cohorts that exclude vulnerable subgroups, such as those in poor health or with complex needs.[14] These elements must be evaluated in advance of additional federal investments in the MA program. Furthermore, a body of research now indicates that older adults (those age 80 and older among whom multiple chronic conditions are more prevalent) are dis-enrolling from MA plans. AHCA strongly recommends that the Work Group investigate such research before investing in a large-scale MA policy option.

    b. *Improving Care Management Services for Individuals with Multiple Chronic Conditions* – As discussed in the background section, in-person, frequent contact with clinicians appears to be a critical aspect of achieving the goals of a multiple chronic condition initiative. AHCA/NCAL suggests that the new code be tested by CMS and include physicians who specialize in caring for skilled nursing center patients and residents (i.e., SNF-ists) with specific care delivery goals associated with IMPACT Act quality reporting measures as well as the SNF rehospitalization program targets.

    c. *Behavioral Health among Chronically Ill Beneficiaries* – Behavioral health and related supports remain a significant challenge both in terms of the availability of behavioral health experts and coordination of acute care with behavioral health

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[13] AcademyHealth. "Improving the Evidence Base for Medicare Policymaking." February 2014

[14] Marcia Gold and Giselle Casillas, "What Do We Know About Health Care Access and Quality in Medicare Advantage Versus the Traditional Medicare Program?" The Kaiser Family Foundation, November 2014.

needs. AHCA/NCAL supports the recommendation that the Government Accountability Office (GAO) study the status of integration of behavioral health and primary care among all Accountable Care Organization (ACO) models. Furthermore, while not proposed by the Work Group, AHCA/NCAL suggests including behavioral health professionals in the CCM code testing with quality outcomes associated with receipt of payment or payment in full. Such an incentive might attract more behavioral health professional to programs targeted to persons with multiple chronic conditions and increase the likelihood they will partner with other specialty providers as well as post-acute and long-term care providers.

3. **Expanding Innovation and Technology** – AHCA/NCAL recognizes the importance of modernizing care delivery and related payment methodology. Advancements in this field must be a key element of any effort. As noted in the background section, communication among providers and across settings is critical. AHCA/NCAL concurs with the Work Group's position that any policy option targeted to this population must foster a cross-setting,ongoing, interdisciplinary, and live information exchange.

    a. *Medicare Advantage* – Regarding the Medicare Advantage recommendations, AHCA/NCAL reiterates the points above regarding the need for availability of data and robust program evaluations in advance of implementing changes on a national level.

    b. *ACOs and Ability to Expand Use of Telehealth* – AHCA/NCAL supports any policies seeking to expand the use of telehealth services, which have proved to improve the coordination of care for patients while controlling costs and maintaining or improving quality outcomes. We recommend lifting both the geographic and originating site requirements entirely rather than specifying additional sites. The Work Group should look to the approach being tested in the Next Generation ACO Model, to be administered later this year by CMMI. The Next Generation ACO model eliminates the geographic and originating site requirement allowing the ACO to more flexibly utilize telehealth services with their aligned beneficiaries.

4. **Identifying the Chronically Ill Population and Ways to Improve Quality –** Identification, and in particular early identification, of chronic conditions can greatly impact disease trajectory and functional status. Accurate payment in the current Medicare and Medicaid fiscal environment is essential.

    a. *Ensuring Accurate Payment for Chronically Ill Individuals* – The CMS-HCC often is criticized for insufficiently risk adjusting. CMS evaluates the HCC on a regular basis and the Affordable Care Act directed CMS to conduct a more in depth evaluation of the HCC. The report is available here. AHCA/NCAL recommends further adjustments to the risk adjustment system; specifically, the Association supports a study on the inclusion of functional status in the HCC. Additionally, the ability for an individual with functional impairments to successfully remain in the community is often dependent on environmental and social support factors that can be captured through the International

Classification of Function, Disability and Health (ICF) developed by the World Health Organization (WHO). As such, AHCA/NCAL recommends a study of incorporating these factors into the HCC risk-adjustment model for this population.

AHCA/NCAL also recommends the Work Group consider other approaches to achieve Medicare efficiencies via more accurate payment for services targeted to persons with multiple chronic conditions. AHCA offers one key concept that could help pay for new benefits or reduce cost sharing for benefits tailored to beneficiaries with multiple chronic conditions. Specifically, AHCA/NCAL has proposed an alternative skilled nursing center payment system that would replace the existing prospective payment system (PPS). AHCA/NCAL's bundled prospective payment system would support implementation of the IMPACT Act by better aligning the skilled nursing center payment system with other post-acute provider payment systems. Such a change would better prepare the post-acute care sector for implementation of a unified post-acute care payment system as described in the IMPACT Act. Additionally, the bundled prospective payment system would be based on condition categories and risk adjusted using, in the short term, the minimum data set (MDS), and in the long term, the IMPACT Act-mandated cross post-acute care setting assessment data. Such a patient coding approach would align with CCM and any other similar codes established for persons with multiple chronic conditions. Condition-specific coding would align with policies and concepts to more quickly identify and track the services and needs of persons with multiple chronic conditions. Furthermore, under our payment reform concept, services would be individually coded on a claim providing CMS with far more detail on the services used by persons with multiple chronic conditions. Finally, AHCA/NCAL commissioned a Congressional Budget Office (CBO)-style score of the proposed payment system. The savings, totaling approximately $1.3 billion over ten years, could be used to pay for policies intended to support persons with multiple chronic conditions.

b. *Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization (ACO)* – In general, AHCA/NCAL supports policies that would improve the flexibility of patients to choose whether or not they are aligned to an ACO. In addition to allowing beneficiaries to "opt in" to an ACO, the Work Group should also recommend the ability for a beneficiary to "opt out" of one completely. AHCA/NCAL strongly supports allowing beneficiaries to retain their freedom of choice of provider, regardless of that provider's alignment or relationship with any particular ACO. The Work Group, however, should use caution in moving too quickly to establish policies that would provide up-front, collective payments to ACOs in the MSSP program. Innovative financial methodologies are currently being tested in the Pioneer and Next Generation ACO models, and CMMI has yet to release any analysis or results detailing how well these new financial arrangements work. The intent of the CMMI ACO initiatives is to test any innovative payment policies on a smaller scale before applying them to the more expansive MSSP program. AHCA/NCAL compels the Work Group to allow CMMI to test new payment arrangements through its demonstrations before expanding them to MSSP ACOs.

c. *Developing Quality Measures for Chronic Conditions* – AHCA/NCAL agrees that the development of measures that focus on health care outcomes for individuals with chronic disease is important. The identified domains of measurement are important areas for high quality, person-centered care of individuals with chronic conditions. AHCA/NCAL is concerned with linking payment to community-level measures over which providers may not always have control or which put providers at odds with residents' personal health-related wishes (e.g., smoking). Although it is important to focus on outcome measures, process measures including screenings should also be considered, as this allows for early intervention, preventing adverse outcomes. AHCA/NCAL has completed extensive work on measures focused upon functional status (e.g., self-care and mobility). We strongly recommend that the Work Group investigate how CMS, specifically the Center for Clinical and Quality Standards, could work more closely with stakeholders and providers regarding the development and use of appropriate quality measures for this population.

5. Empowering Individuals & Caregivers in Care Delivery Policy under Consideration

-- Historical research on care models for persons with chronic conditions highlights the importance of educating and engaging both patients and caregivers in their healthcare.

a. *Encouraging Beneficiary Use of Chronic Care Management Services* – AHCA/NCAL supports the notion of waiving the CCM cost sharing fee as well as the proposed high severity chronic care code, above. However, any offsets needed to pay for the elimination of cost sharing should be based on quality improvement and related reduced health care utilizations (e.g., avoidable hospitalizations, etc.) and not reductions in payment to health care providers attempting to delivery care to an already complex and costly population. In addition, skilled nursing facilities should be included in the CMS CCM program. By allowing for the incentive to be payable through institutional claims, CMS would assure adherence to the provisions of ACA and facilitate IMPACT Act monitoring of Resource Utilization and Quality Measurement. Currently, CMS ignores the volume of chronic conditions managed through skilled nursing facilities and assisted living facilities providing rehabilitation services. By limiting the CMS claim type used for the CCM Program, caregivers of the largest segment of those with chronic conditions are excluded and beneficiary services endorsed by this program are not adequately captured in CMS data collection.

b. *Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness* – AHCA/NCAL supports the concept of a one-time post-diagnosis payment and related code. In accordance with our comment above, however, any offset for the additional payment should come from quality improvement, not from rates. In terms of how such a payment a code might operate, AHCA/NCAL suggests

using the ICD-10 coding system to identify such individuals and utilizing those codes to qualify them for post diagnosis visits. Providers eligible for such payments should include key specialists such as nephrologists, neurologists, endocrinologists, and cardiologists. AHCA/NCAL also would recommend the inclusion of psychiatrists who specialize in the care of persons with Alzheimer's and related dementia. In terms of interaction with the CCM, AHCA/NCAL envisions the post-diagnosis payment provided first and if the patient elects to participate in CCM with their practitioner, CCM payment beginning afterwards.

c. *Eliminating Barriers to Care Coordination under Accountable Care Organizations* – AHCA/NCAL strongly maintains that any attempt to allow ACOs to waive beneficiary cost sharing go through the rulemaking process, so that there is transparency and uniformity as to what is defined as "items/services that treat a chronic condition or prevent the progression of a chronic disease." We are concerned that allowing ACOs to define for themselves what constitutes a chronic disease may cause unnecessary confusion among skilled nursing providers, particularly those who work with multiple ACOs and must manage multiple sets of criteria and requirements.

6. **Other Policies to Improve Care for the Chronically Ill –** AHCA/NCAL offers comments on the work group developed options.

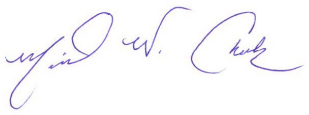
   a. *Increasing Transparency at the Center for Medicare & Medicaid Innovation (CMMI)* – CMMI is essential to modernizing the Medicare and Medicaid programs. However, as with any other division making changes to Medicare and Medicaid, CMMI should be held accountable to public input upon all changes to Medicare and Medicaid. AHCA/NCAL recommends that benchmarks be set for the number of people impacted as well as the amount of Medicare spending impacted. Such benchmarks would be used to determine how much stakeholder input is warranted. For example, for large scale demonstrations (e.g., spread across the country, etc.), a Request for Information (RFI) should be required before a notice of proposed rulemaking (NPRM) or a proposed rule is issued or for any new or revised quality measure related to the program prior to submission to National Quality Forum (NQF) for endorsement. Direction is needed to assure CMMI seriously considers and implements quality measures that have proven valid. Use of Quality Measures that have a direct impact on patient care and Provider payment should not be those provided only as a "Measure Under Consideration" (MUC). MUC List items may serve for research or trial demonstrations but only Quality Measures that have been tested and have research to support validity should be applied to programs impacting Medicare beneficiary clinical care and the associated Provider payments. Additionally, AHCA/NCAL proposes a mandatory 60-day comment period for any NPRM or proposed rule launching a new program and a minimum of 30 days for any regulation expanding or altering an existing program. Finally, we believe the rulemaking process as laid out in the Administrative Procedures Act should be required for any changes to a given model. Rapid cycle innovation is important but ceases to serve beneficiary needs when demonstrations are expanded or

extended with no or weak findings to support such steps. Public input would offer checkpoints for rapid cycle modifications.

b. *Studies on Medication Synchronization and Obesity Drugs* – AHCA/NCAL supports both studies.

The Association appreciates the opportunity to provide comments and would welcome the opportunity to meet with members of the Work Group and Work Group staff. Please contact Kim Zimmerman at kzimmerman@ahca.org or Michael Bassett at mbassett@ahca.org. We look forward to working with on the development of these, and other, ideas aimed at supporting persons with chronic conditions.

Sincerely,



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