AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 11, 2017

VIA ELECTRONIC MAIL
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Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: CMS-1678-P, FY 2018 Hospital Outpatient Prospective Payment System (OPPS) Notice of Proposed Rulemaking

Dear Ms. Verma:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2018 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. Our organization is the policy voice for five Seventh-day Adventist health systems that include 82 hospitals and more than 300 other health facilities in 17 states and the District of Columbia.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to California. Therefore, we believe that we can provide an objective and sound policy voice in response to CMS' OPPS proposed rule. Below please find AHPA's comments and recommendations to CMS' proposed policies. Specifically, we comment on the following five issue areas:

- 340B Drug Program Payments
- Changes to the Inpatient Only (IPO) List
- Proposed Removal of Outpatient Quality Reporting Program Measures
- Public Reporting of OP–18c
- Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) Measures

340B Drug Program Payments

Beginning in FY 2018, CMS proposes to reduce Part B drug payments to 340B hospitals for all separately payable drugs by nearly 30 percent, from Average Sales Price (ASP) plus six percent to ASP minus 22.5 percent. In the rule, CMS expressed concern that the current payment methodology for Part B drugs may lead to unnecessary utilization and potential overutilization of separately payable drugs at 340B hospitals. The rule cites a Government Accountability Office (GAO) 2015 report, which found that the per beneficiary Part B drug spending, including oncology drug spending, was more than twice as high at 340B disproportionate share hospitals than at non-340B DSH hospitals.

AHPA recommends that the Agency *not* reduce Medicare payments to 340B hospitals. This proposal would hinder the ability of 340B hospitals to serve low-income and rural patients, which would undermine the goals of the 340B program. Per the statute, the 340B program was created to, "allow certain providers to stretch scarce federal resources." Therefore, a payment reduction as significant as the one proposed by CMS would undermine the effectiveness of the 340B program and would diminish federal resources further. A survey conducted by 340B Health revealed that nearly 60 percent of their member hospitals are likely to withdraw from the 340B program if the proposed reduction to the Part B drugs were finalized.

We are concerned that CMS' proposal does not adequately account for the costs incurred by 340B hospitals to comply with the 340B program. This includes complying with the statute's Group Purchasing Organization (GPO) prohibition, which prevents Disproportionate Share Hospital (DSH) qualified 340B hospitals from using a GPO for purchasing covered outpatient drugs at any point in time. To maintain compliance with the 340B program, many hospitals must also maintain software, hire staff, and conduct paid audits. In addition to these costs, CMS' proposal fails to incorporate the costs of purchasing drugs through a Wholesale Acquisition Cost (WAC) account for 340B hospitals. It presumes that all drugs are purchased at the 340B discount. By not accounting for these costs, the proposed payment reduction would make it very difficult for hospitals to continue participating in the 340B program. The inability of hospitals to continue providing these drugs would have an adverse effect on low-income patients who may find it difficult to access the drugs, as physician offices are not as willing to accept the financial risks of treating under or noninsured patients. **Therefore, we recommend that CMS adopt a different payment rate to account for the costs incurred by 340B hospitals.**

According to CMS, the reduced reimbursement is appropriate due to the growth in the 340B program and high drug costs. However, addressing high drug costs by lowering reimbursement to those dispensing the drugs will do nothing to lower the inflated prices charged by pharmaceutical companies. The proposed payment reduction will only make it more difficult for hospitals to purchase these drugs and provide them to patients in need. **In addition to threatening patient access to these drugs, the proposal will not result in any savings to Medicare beneficiaries**. While the copayments for Medicare Part B drugs would decrease under the proposal, the copayment for other outpatient services would increase. This is due to CMS' plan to implement the proposal in a budget neutral manner. According to the proposal, CMS would use the 340B savings to increase payments for other Medicare services paid under OPPS. The Agency estimates that OPPS payment rates would increase by about 1.4 percent in CY 2018 due to the redistribution of savings. Thus, the proposed payment reduction would undermine the 340B program and produce no savings for Medicare beneficiaries.

AHPA is also concerned that the methodology in the GAO study that CMS referenced in support of its proposal to reduce 340B payments is not accurate. The study concluded that 340B hospitals are providing more drugs or more expensive drugs to Part B beneficiaries in potentially inappropriate ways, which we disagree with. The study assumed that 340B hospitals prescribe more drugs than other hospitals

because of the 340B program drug discount. However, the GAO did not fully account for differences in the patient populations between 340B and non-340B hospitals that could explain the spending differences. As noted in the same report, outpatient Medicare margins are lower in 340B hospitals than non-340B hospitals. This could be attributed to 340B hospitals treating more expensive patients compared to other hospitals, which would increase their costs and lower their margins. In commenting on this study, the Department of Health and Human Services (HHS) agreed with these observations. HHS raised concerns with the GAO's conclusions and suggested that further analysis may be needed to examine patient outcomes and differences in health status.[1] The Agency further noted that higher volume of physician-administered drugs can lead to better clinical outcomes. Therefore, we are surprised that CMS has referenced a study previously opposed by HHS to justify the proposed payment reduction.

Furthermore, it is unclear whether CMS has the statutory authority to reduce payments to 340B hospitals. In the same report referenced above, the GAO stated the following:

> "While limiting hospitals' Medicare Part B reimbursement for 340B discounted drugs or eliminating the 340B discount for drugs provided by hospitals to Medicare Part B beneficiaries could diminish the incentive to prescribe more drugs or more expensive drugs than necessary at 340B hospitals, CMS and HRSA are unable to take such actions because they do not have the statutory authority to do so."[2]

Based on the GAO's conclusion, we believe that a legal analysis should be performed to verify whether the Agency has the statutory authority to implement the proposed payment reduction.

Redistribution of 340B Savings

As mentioned earlier, CMS proposes to redistribute all or some of the savings resulting from the 340B payment reduction to increase payments for certain services paid under the OPPS. CMS seeks comments on how to redistribute these savings and whether the proposal would result in unnecessary increases in the volume of covered services paid under the OPPS.

AHPA is significantly concerned about this proposal because the redistribution of 340B funds across other OPPS services could mean that non-340B hospitals would receive increased payments. This could also result in savings from the 340B discount being passed on to others reimbursed under the OPPS, such as Durable Medical Equipment suppliers, Ambulatory Surgery Centers (ASCs) and independent labs. We believe that this would be a violation of the 340B program statute, which requires hospitals to treat a disproportionate share of Medicaid patients to participate in the program and qualify for the savings.

[1] GAO-15-442. (June 2015). Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals, p.38. Retrieved at: https://www.gao.gov/assets/680/670676.pdf

[2] GAO-15-442. (June 2015). Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals, p.35. Retrieved at: https://www.gao.gov/assets/680/670676.pdf

Modifier for Non-340B Drugs and Potential Reporting of 340B Acquisition Cost

CMS proposes to require hospitals to use a new modifier to identify non-340B separately payable drugs reimbursed by Medicare Part B under the OPPS. CMS will presume that drugs without the modifier were purchased under the 340B program. Therefore, failure to include a modifier would result in a claim being paid at ASP minus 22.5 percent. Although non-340B hospitals will not be subject to reduced reimbursement under this proposal, they will still be required to use the modifier to indicate that drugs were not purchased under the program. CMS suggests that the modifier's purpose is to allow CMS to identify the acquisition cost of 340B drugs.

AHPA opposes the adoption of this new modifier. We believe that its adoption would add significant administrative burden to non-340b facilities. Implementing it would require hospitals to maintain two separate bill code schedules within their Electronic Health Record (EHR) domains, one for 340B sites and another for non-340 sites. The current single modifier schedule for Medicare contains any modifiers that CMS specifically requires, such as the GP, GO or GN modifiers. Therefore, this policy would necessitate an additional schedule in the EHR that would have to be maintained and updated. In addition to this being administratively burdensome, it would also be costly for health care providers to implement. Hospitals would need to upgrade their EHRs and potentially hire additional staff to ensure compliance. Additionally, due to limitations with the Electronic Medication Administration Record (eMAR) system and billing, most hospitals would not be able to indicate when a drug was purchased at WAC and add CMS' proposed modifier to indicate a non-340B drug. Therefore, WAC purchases would likely be reimbursed at the proposed ASP minus 22.5 percent as well. Based on these issues, we strongly advise against the adoption of this modifier.

Impact on AHPA

AHPA covered entities and the communities they serve would be negatively impacted if CMS finalizes the proposal to reduce Part B drug payments for all separately payable drugs by nearly 30 percent. The financial impact of the proposed cuts would be significant. For example, at Florida Hospital's Central Florida Division, which is composed of eight hospitals including a Children's Hospital, the annual payment impact to the infusion business would be approximately $1.9 million. In one of our rural facilities, such as Park Ridge Hospital in North Carolina, the impact of the proposed cuts would be $670,698. This would severely limit the ability of these hospitals to provide needed drugs to patients. The cuts could drive facilities to reduce the number of discounted and free drugs given to patients who are discharged from the hospital, but are unable to afford their medications.

Currently, the 340B program savings are reinvested in several programs designed to increase access to prescription medicines and other health services for low-income patients. Losing those savings may affect the long-term viability of those programs. For example, Adventist GlenOaks Hospital is a rural hospital within the AHPA system located in Glendale, Illinois. This 340B covered entity uses the savings from the program to provide a medication reconciliation and bedside medication delivery. The hospital devotes one full time pharmacist to managing both admission and discharge medication reconciliation, with much of the cost being recouped by 340B savings. Because of this program, GlenOaks can deliver medications to the bedside of approximately 50 percent of their patients and have a pharmacist provide medication and disease state counseling. Their pharmacists also utilize 340B pricing on critical medications like insulin to provide affordable or free medication to uninsured or underinsured patients at the time of discharge.

Due to the reasons outlined above, an advisory committee to HHS, the Hospital Outpatient Panel (HOP), also expressed opposition to CMS' proposed cuts to the 340B program on a meeting that took place on August 21st. At that meeting, the American Hospital Association indicated that its contractor, Watson

Policy Analysis, estimated the savings associated with CMS' 340B proposal at $1.65 billion or $750 million more than CMS' $900 million savings estimate.

In conclusion, the 340B prescription drug program is a vital lifeline for safety-net providers and supports critical health services in our communities. The program is narrowly tailored to reach only hospitals that provide a high level of services to low-income individuals or that serve isolated rural communities. Savings from the 340B program help hospitals meet the health care needs of underserved patients across the country. Congress should preserve and protect the 340B program as an essential part of the safety-net that does not rely on taxpayer dollars.

Changes to the Inpatient Only (IPO) List

CMS seeks comments on its proposal to remove the procedures below from the Inpatient Only (IPO) list for CY 2018.

- **Total Knee Arthroplasty** (TKA)- CPT Code 27447
- **Total Hip Arthroplasty** (THA)- CPT Code 27130
- **Partial Hip Arthroplasty** (PHA)- CPT Code 27125

According to CMS, these procedures meet several of the criteria used by the Agency to determine whether a procedure can be removed from the IPO list and assigned to an Ambulatory Payment Classifications (APC) group for payment. The five criteria are as follows:

1. Whether most outpatient departments are equipped to provide services to the Medicare population or whether the procedures are related to codes that CMS has already removed from the IPO list.
2. The simplest procedure described by the code may be performed in most outpatient departments.
3. The procedure is related to codes that we have already removed from the IPO list.
4. A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis.
5. A determination is made that the procedure can be appropriately and safely performed in an ASC, and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC.

In the rule, CMS states that that the TKA procedure meets a number of criteria for removal from the IPO list, including criteria 1, 2 and 4. From this statement, **we infer that because the TKA procedure does not meet criteria 5, if it were removed from the IPO list, the procedure would not be allowed to be performed in the ASC setting. However, we ask that CMS clarify whether this is true.** We believe it would be unsafe for providers to perform such procedures in ASCs due to the age and medical complexity of the Medicare population. Patients should be treated in the most appropriate setting depending on their age and clinical characteristics. For example, while age alone does not disqualify a patient's ability to have a successful outpatient surgery, age can affect the reaction a patient has to certain anesthetic drugs.[3]

Moreover, AHPA does not agree that CMS should remove the proposed procedures from the IPO list. Due to the clinical characteristics of TKA, THA and PHA, we believe these procedures should not be performed in the outpatient setting and should therefore be retained in the IPO list. For example, TKA procedures involve hospitalizations of 72 hours or more in which the patient can experience significant

[3] http://www.hopkinsmedicine.org/healthlibrary/conditions/surgical_care/outpatient_surgery_85,P01404/. Retrieved on August 25, 2017.

blood loss. Patients undergoing TKA are at a higher risk of postoperative anemia and may also require allogeneic blood transfusions.

While a younger and healthier non-Medicare population may be able to safely undergo these procedures in the outpatient setting, Medicare patients are far more likely to suffer from conditions that would be contraindicative for an outpatient surgery. According to a report by CMS, two-thirds of Medicare beneficiaries have multiple chronic conditions.[4] Conditions such as high blood pressure, high cholesterol, heart disease and diabetes are highly prevalent among the elderly population. Both the age and existing comorbidities of Medicare patients, particularly heart failure, increase the risks associated with an outpatient THA, TKA or PHA.

Evidence also suggests that patient outcomes are worse when a TKA is performed in the outpatient setting. A study released in May 2016 demonstrates that outpatients undergoing TKA continue to experience higher rates of post-discharge complications than inpatients, which may countermand cost-savings. The study found that most TKA complications involved bleeding requiring transfusion, which occurred at similar rates after surgery but at higher rates post discharge in outpatients. In the outpatient setting, 7.5 percent of patients had complications after TKA surgery, compared to 5.6 percent in the inpatient setting. After discharge, 4.1 percent of outpatients had complications, compared to only 0.1 percent for inpatients.[5] The data came from an analysis of patients undergoing TKA between 2011 and 2013. Another study released in 2012 found that patients having TKA as outpatients were significantly more likely to die or need readmission within 90 days compared with inpatients remaining in the hospital for three to four days.[6]

While total knee replacements may be performed safely in the outpatient setting for young and generally healthy patients, we do not believe the same holds true for Medicare patients. Patients undergoing a TKA procedure often experience significant post-operative pain. Inadequate pain relief can cause delayed mobilization, greater risk of developing venous thrombosis, coronary ischemia and poor wound healing.[7] Discharging patients home a few hours after a TKA shifts the responsibility of adequate pain management to the patient, much earlier than if that patient stays in a hospital setting or any other adequate setting. This may significantly increase the risks associated with performing a TKA on a Medicare patient. Particularly in the elderly population, our goal is to optimize the post-operative care in the hospital setting to allow the patient to return home safely. This promotes healthier recovery for the patient and allows them to participate more actively in outpatient therapy services. **Based on these patient safety issues, we ask that CMS reconsider its proposal to remove TKA from the IPO list. We believe that CMS should consider the quality of outcomes to beneficiaries before considering cost savings.**

AHPA is also concerned that removing the proposed procedures from the IPO list will lead to Medicare Recovery Audit Contractors (RACs) pressuring health care providers to perform these services in the hospital outpatient setting. This pressure may lead to the treatment of patients in a setting inappropriate to their health care needs. To address this issue, CMS proposes to prohibit RAC patient status reviews for TKA procedures performed in the inpatient setting for a period of two years. According to the Agency, this will give providers time and experience performing TKA under the outpatient setting.

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[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf. Retrieved on August 28, 2017.
[5] "Is Outpatient Arthroplasty as Safe as Fast-Track Inpatient Arthroplasty? A Propensity Score Matched Analysis." Retrieved at: http://www.ncbi.nlm.nih.gov/pubmed/27378634
[6] "Outpatient Total Knee Arthroplasty: A Cost and Outcomes Analysis" Retrieved at: http://bit.ly/2bLhCuZ
[7] "Acute Postoperative Pain Following Hospital Discharge After Total Knee Arthroplasty" Retrieved at: http://www.oarsijournal.com/article/S1063-4584(13)00847-9/fulltext

While we appreciate CMS' effort to address these concerns, we believe that adopting a transition period of two years will not address the underlying issue of Medicare contractors questioning physician decision-making. **To avoid this issue, we recommend that CMS work with specialized organizations to establish specific criteria for when a TKA can be performed in the outpatient setting.** For example, CMS could work alongside the American Academy of Orthopaedic Surgeons (AAOS) to create evidence-based patient selection criteria to identify patients who are appropriate candidates for an outpatient surgery. CMS could also work with the Hip/Knee Society to establish the criteria for same-day joint replacements. **Moreover, we recommend that CMS postpone the removal of TKA from the IPO list until such nationwide standards are developed.** Having set standards will help ensure patient safety, avoid potential claim denials, and increase uniformity among provider services.

Impact of Proposal on Medicare Payment Models

As noted by CMS, removing TKA from the IPO list would affect the implementation of Medicare payment models such as the Comprehensive Joint Replacement (CJR) model and the Bundled Payments for Care Improvement (BPCI) initiative. Under both models, a hospital's actual expenditures are reconciled against a target price for an episode of care. If a hospital's cost of care is less than the target price, the hospital receives a reconciliation payment from CMS. If the actual cost of care is more than the target price, the hospital is required to pay the difference to CMS. The episode target prices are currently based on a blend of hospital-specific data and regional historical data. Because TKA has always been under the IPO list, there is no claims history for beneficiaries receiving these services on the outpatient setting.

If CMS were to remove TKA from the IPO list, causing many patients to shift to the outpatient setting, the current target prices would no longer be an accurate predictor of episode spending. These target prices would need to be modified to ensure that they accurately reflect the costs associated with treating patients in both the inpatient and outpatient settings. Moreover, they would need to be adjusted to account for those more medically complex patients that continue to receive TKA procedures as inpatients. The failure to accomplish this may impact a hospital's ability to maintain costs within the target rate. Based on these issues, we believe that removing TKA from the IPO list would compromise the validity of both the CJR and BPCI models.

Further, the proposal to remove TKA and THA from the IPO list would also have significant implications on the Hospital Readmission Reduction Program (HRRP) and the Value-Based Purchasing Program (VBP). Because TKA/THA are included in both programs, their removal from the IPO list would require CMS to make changes to those programs' baseline and performance periods. For example, for FY 2019, the baseline period for TKA/THA in the VBP program is July 1, 2010 to June 30, 2013. The performance period is January 1, 2015 to June 30, 2017. Because the data captured during these periods does not account for procedures performed in the outpatient setting, CMS would need to either change these periods or postpone the proposal's implementation date.

Impact to Medicare Beneficiaries

We seek clarification on whether CMS has conducted an analysis on the financial impact of the proposed changes to Medicare beneficiaries, specifically as it relates to their cost-sharing responsibilities. Performing these procedures in the outpatient setting would increase the cost-sharing liability for Medicare beneficiaries and make them ineligible for Medicare coverage of Skilled Nursing Facility (SNF) services. Patients would be required to pay for the cost of their SNF care, which may inhibit their ability to receive those post-discharge needed services. This may consequently result in

hospital admissions and higher health care costs. Therefore, we recommend that CMS conduct further analysis on both the clinical and financial impact of this proposal on Medicare beneficiaries.

If CMS finalizes the removal of these procedures from the IPO list, we also ask the Agency to clarify whether hospitals would have to provide a notice to Medicare beneficiaries informing them of these changes and their financial implications. As the health care industry shifts towards a more consumer-centric model of care, we believe that CMS should take a more active role on educating beneficiaries on Medicare policy. Currently, hospitals have been forced to perform a customer service role for CMS, explaining to beneficiaries what patient status they are in and what implications that had. These issues are being caused by CMS' policies and yet hospitals have to be in the front lines defending said policies to beneficiaries who contest them.

Hospital Outpatient Quality Reporting (OQR) Program

Proposed Removal of OQR Measures

For the Outpatient Quality Reporting Program (OQR), CMS proposes to remove six measures and three ASC QRP measures. For the CY 2020 payment determination, CMS proposes to remove the following:

Proposed measure	Measure ID	Quality reporting program	Payment year of proposed removal	Measure source
Prophylactic Intravenous Antibiotic Timing	ASC-5	ASCQR	CY 2019	Claims-based
Safe Surgery Checklist Use	ASC-6	ASCQR	CY 2019	Web-based
ASC Facility Volume Data on Selected Procedures	ASC-7	ASCQR	CY 2019	Web-based
Median Time to Fibrinolysis	OP-1	OQR	CY 2021	Chart-abstracted
Aspirin at Arrival	OP-4	OQR	CY 2021	Chart-abstracted
Door to Diagnostic Evaluation by Qualified Medical Professional	OP-20	OQR	CY 2021	Chart-abstracted
Median Time to Pain Management for Long Bone Fracture	OP-21	OQR	CY 2020	Chart-abstracted
Safe Surgery Checklist Use	OP-25	OQR	CY 2021	Web-based
Hospital Outpatient Volume Data on Selected OP Surgical Procedures	OP-26	OQR	CY 2020	Web-based

AHPA supports CMS in removing the proposed measures from the OQR program. We agree with CMS' conclusion that the above process measures do not improve the quality of care for Medicare beneficiaries. We recommend that CMS use the same rational to remove other process measures currently adopted in hospital performance programs. We believe that this would support the shift from process measures to outcome-based measures.

Public Reporting of OP–18c

Beginning in July 2018, CMS proposes to require the public reporting of the measure OP-18c: Median Time From Emergency Department Arrival to Emergency Department Departure for Discharged Emergency Department Patients—Psychiatric/Mental Health Patients. No new data collection would be required for this measure. Hospitals would be able to preview the data to be reported for OP-18c as part of the regular 30-day data preview process.

We commend CMS' effort to address the mental health gap in the publicly reported hospital OQR measure set. We agree that capturing the quality of mental health services is essential to improving health care outcomes. The OP-18c is a process measure that solely assesses the time taken by hospitals to admit and discharge mental health patients. If CMS decides to report this measure, then it should derive a formula that considers two factors: the number of licensed mental health providers that service Medicare, Medicaid and the uninsured in the community where the hospital is located, and the time it took the hospital to consider the release time of the patient. Both numbers will more accurately reflect the factors that can affect a patient's outcome that are beyond the provider's control (such as an absence of mental health facilities in the provider's area).

Because there is currently a nationwide shortage of mental health resources, the time taken by hospitals to discharge mental health patients will depend significantly on the availability of resources in the community.[8] Therefore, this metric may be interpreted by the public as if hospitals are performing poorly in mental health even though the delays are more likely attributed to a public health issue. **Due to this issue, we recommend that CMS delay the public reporting of OP-18c and instead focus on outcome-based measures for behavioral health.** If CMS were to adopt this measure for public reporting, we recommend that CMS include the qualifier of number of licensed mental health providers serving Medicare, Medicaid, and the uninsured in the community where the hospital is located. We believe this metric should be part of an equation and not a stand-alone number.

Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey

CMS proposes to delay indefinitely the implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) measures, currently scheduled for inclusion in the OQR Program measure set beginning with 2020 payment (2018 data collection).

AHPA believes in the importance of assessing patient experience in the ambulatory surgical setting. However, we think that the timeline for the OAS CAHPS survey tool has moved too quickly, as compared to other CAHPS instruments in the past. **Therefore, we support this delay and ask that CMS**

[8] The American Hospital Association. The State of the Mental healthWorkforce: A Literature Review. Retrieved at: http://www.aha.org/content/16/stateofbehavior.pdf

spend time, with input from the health care industry, evaluating the utility of the specific questions and the length of the survey.

Conclusion

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Julie Zaiback, Director of AHPA, at Julie.Zaiback@ahss.org.

Sincerely,

Jeff Bromme
President
Adventist Health Policy Association