THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading change. Improving care for older adults.

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October 3, 2016

SUBMITTED ELECTRONICALLY VIA
http://www.regulations.gov

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5519-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) (CMS-5519-P)

Dear Mr. Slavitt:

The American Geriatrics Society ("AGS") appreciates the opportunity to comment on the *Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Mode (CJR) (CMS-5519-P)* (the "Proposed Rule").

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners ("NPPs") who are devoted to improving the health, independence and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our vision for the future is that every older American will receive high quality patient-centered care. In order to achieve this vision, we strive to help guide the development of public policies that support improved health and health care for seniors.

As the healthcare providers for older adults, particularly those with multiple chronic and complex conditions, we believe that the new proposed episode payment models ("EPMs") must be undertaken in a way to ensure that the most vulnerable beneficiaries who are at high risk for adverse events, death and complication, receive the care they need. Our primary recommendations for tailoring the Proposed Rule to meet the needs of Medicare's most vulnerable beneficiaries include:

RECOMMENDATIONS

1. **Initial efforts should focus on validity of the EPM designs, not the volume of services or amount of costs that are covered. Priority should be placed on a small set of EPMs that have the support of the specialties that provide the key services within the episodes.**

2. **The AGS has worked closely with CMS over the past several years to add new CPT codes and Medicare payment for services such as transitional care management, chronic care management, and advance care planning, and appreciate many of CMS' proposals in the 2017 Proposed Rule for the Physician Fee Schedule to create new G codes for certain services and establish payment for E/M codes that are not currently paid by Medicare. We refer CMS to our comments on the Proposed Rule and strongly urge CMS to finalize the proposals with the modifications described therein.**

3. **With regard to both the EPMs discussed in this Proposed Rule and as a general matter going forward, we want to voice our concerns about the level of control given to hospitals over the amount of gainsharing payments and their allocation as well as the potential consequences to beneficiary choice and the fairness of how gainsharing payments are allocated to EBM collaborators. AGS encourages CMS to modify its proposal for allowing hospitals broad discretion to determine how they identify and choose EPM collaborators and the methodology for sharing payments with those EPM collaborators so as to allow for greater input from collaborators and additional safeguards designed to ensure beneficiary choice and payment fairness.**

4. **As a general matter, AGS encourages CMS to ensure far greater involvement of physicians and the professional societies that represent them in future efforts to design, evaluate, and implement EPMs. Additionally, we urge CMS to proceed carefully given the current lack of experience of specialized payment bundles for the frail and/or medical complex population. We are concerned that a mandatory program will burden small and rural providers, potentially restricting access to care and creating incentives to avoid admitting the frailest patients.**

5. **AGS urges CMS to implement a broad-based educational campaign regarding the new EPMs that uses all of CMS' communication channels to reach hospitals, post-acute care providers, physicians, and community-based providers of long-term care services and supports.**

6. **AGS urges CMS to make more of its methodologies, data, and mathematical modeling not only transparent to the public, but digested and presented in ways that physicians can readily understand and grasp the implications for their practices.**

7. **AGS urges CMS to work with the Quality Improvement Organizations (QIOs) to help providers in geographic areas work together to build infrastructure for care coordination activities, such as standardized forms, workflows, and processes for coordinating with community-based organizations.**

8. **The final rule should provide for a serious role for community-based organizations, allowing them to be part of contracting and gain-sharing.**

9. **AGS urges CMS to establish adequate measures to evaluate frail elderly beneficiaries' access to care planning, palliative care, long-term care services and supports, and behavioral health services.**

10. **CMS should generate and use metrics that directly monitor transition quality.**

11. **CMS also must consider how to address attribution issues with a much greater degree of specificity than used in its various pay-for-performance initiatives to date.**

12. **We urge CMS to continue to develop and use measures that reflect patient clinical outcomes and functional status following particular interventions or periods of care.**

13. **We urge CMS to modify its proposal so that beneficiaries are held harmless for non-covered skilled nursing facility (SNF) services for which they are referred by the originating hospital, regardless of whether a discharge planning notice is provided.**

Below we describe the rationale for our recommendations in more detail.

A. Selection of Episodes for Episode Payment Models in this Rulemaking and Potential Future Directions

AGS appreciates CMS' request for additional information on future EPMs and the opportunity to provide our general comments. **Initial efforts should focus on validity of the EPM designs, not the volume of services or the amount of costs that are covered. Priority should be placed on a small set of EPMs that have the support of the specialties that provide the key services within the episodes.** By looking retrospectively at patients who had costly cases, it is possible to determine why a patient had high costs (such as an inpatient stay) but often less clear what interventions could have prevented the inpatient stay in the first place. Sometimes the patient's entry into the hospital could have been prevented through better care coordination, but neither care coordination, nor the lack thereof, can be deduced by analyzing Medicare claims.

For services such as care coordination, which are not fully covered by Medicare, an EPM may offer the flexibility to cover these services, but CMS must plan specifically to measure the use of these services. If episodes are built on claims data and a lot of services physicians provide in an APM are not separately payable by FFS Medicare, they will be left out of the episode. For a stroke patient, for example, there may be claims from many different physicians and other professionals, but there will not be a claim for a team leader who is coordinating the overall care of the patient because Medicare does not pay for this service. For this reason, AGS believes that it is imperative that CMS provide more explicit incentives for individual physicians to coordinate care amongst themselves. New codes are needed to adequately identify and value the cognitive services and collaborative work that go into modern medicine.

The AGS has worked closely with CMS over the past several years to add new CPT codes and Medicare payment for services such as transitional care management, chronic care management, and advance care planning, and appreciate many of CMS' proposals in the 2017 Proposed Rule for the Physician Fee Schedule to create new G codes for certain services and establish payment for E/M codes that are not currently paid by Medicare. We applaud CMS' proposals in the 2017 Proposed Rule for the Medicare Physician Fee Schedule to make separate payment for CPT codes 99354 (prolonged E/M service with direct patient contact), and 99358 and 99359 (prolonged E/M service without direct patient contact). AGS also appreciates CMS' proposing new G codes for behavioral health integration, and assessment and care planning for patients with cognitive impairment. We strongly recommend that CMS finalize its proposals to make separate payment for CPT codes 99487 and 99489 (complex chronic care management) and to base payment on the RUC recommendations for physician work and practice

expense inputs. We strongly recommend that CMS finalize all its proposals with respect to initiating visits, electronic records, access and continuity and consent to facilitate access to care coordination services. We urge CMS to finalize those proposals with the modifications recommended by the AGS and the multispecialty coalition we have led. By recognizing and valuing these services, CMS will begin to obtain real data from Medicare claims about the significant time that geriatricians spend managing the care of our patients with multiple chronic conditions. This information will help CMS and specialty societies design future EPMs that incentivize care coordination activities.

The Proposed Rule establishes a retrospective episode payment system that reconciles actual spending with a quality-adjusted target price. CMS would allow EPM participants to enter into "sharing arrangements" with providers caring for EPM beneficiaries, and establishes parameters regarding how participant hospitals may enter into sharing arrangements, how collaborators may be chosen, the structure of the arrangements with collaborators, and other limitations on those relationships and payments. AGS agrees with many of the parameters and safeguards that CMS proposes and we appreciate the difficulties in developing payment methodologies that balance accountability and fairness. However, we are concerned about the direction CMS is taking with some alternative payment models, especially EPMs centered around a brief hospitalization where most of the relevant care is provided in the community. **Specifically, with regard to both the EPMs discussed in this Proposed Rule and as a general matter going forward, we want to voice our concerns about the level of control given to hospitals over the amount and allocation of gainsharing payments and the potential consequences to beneficiary choice and fairness to collaborators.**

While CMS acknowledges that "providers, suppliers, and ACOs may invest substantial time and other resources in [EPM] activities," hospitals have broad discretion regarding how and to what extent gainsharing payments and other savings are shared with providers. In fact, with regard to these EPMs, hospitals have **no** obligation to share these payments with the collaborators at all -- even though they are often supplying the majority of the care in an episode.

AGS is concerned about the consequences of providing hospitals with unilateral discretion over distribution of these payments. While these episodes are tied to a hospital admission, it is the physician (or other provider -- who referred the patient to the hospital for the relevant procedure, performed the procedure, and who will care for the patient for 90 days post-discharge -- who have the greatest responsibility, and control, over the quality and cost of the patient's care. Likewise, these providers should have responsibility for, or at the very least meaningful input into, how payments, whether they are gainsharing, alignment, or internal cost savings, are distributed. Put another way, the admitting physician may be responsible for all the internal cost savings of the hospital and therefore should be deeply involved in how the gainsharing payments should be made. While CMS clearly contemplates that hospitals enter into sharing arrangements, CMS' proposal to leave that discretion to the hospitals will have the unintended consequence of further consolidating control of care at the hospital-level rather than with the community providers at the forefront of providing patient-centered care, and could restrict beneficiary choice. We are very concerned that hospitals will steer patients toward certain collaborators, or non-collaborators, thereby disrupting patient-physician relationships and possibly impairing the quality of care if those collaborators are not specialists in geriatric care.

While we appreciate CMS's efforts to ensure that hospitals' selection of EPM collaborators eligible for sharing arrangements is based in part on quality, irrespective of volume or value of their referrals, and attempts to include safeguards that are intended to preserve beneficiaries' choice of

provider, there is still a significant risk that hospital discretion over these arrangements will incentivize hospitals to restrict EPM collaborator status to a small group of preferred providers and establish narrow referral networks in order to control costs that aren't necessarily in the best interest of patients. The beneficiaries receiving care through these EPMs are often complex, older patients who need the care of experienced geriatricians. We believe that stronger safeguards need to be put in place, as a general policy matter, now before these models are implemented, and CMS needs to closely monitor referral patterns going forward, to ensure that payment models are not diminishing patient choice or disrupt existing provider-patient relationships, which are paramount for ensuring patient-centered, continuity of care. In essence, hospitals' discretion in choosing collaborators should be limited and hospitals should be required to make gainsharing payments to collaborators who provide care to EBM patients.

To that end, we encourage CMS to modify its proposal for allowing hospitals broad discretion to determine how they identify and choose EPM collaborators and the methodology for sharing payments with those EPM collaborators. First, providers who are furnishing EPM services should be part of the decision-making process with respect to determining the amount and allocation of gainsharing payments. Providers furnishing a minimum percentage of EPM services should be required to be part of the EPM participant governance structure that develops the written policies regarding EPM collaborators and the methodology for sharing arrangements, including the arrangements that affect the amount and allocation of gainsharing payments. Second, CMS should establish additional safeguards to ensure that gainsharing and other cost savings are fairly distributed. To prevent hospitals from establishing very narrow EPM collaborator lists, hospitals should be required to allow any interested provider who meets basic, minimum quality standards and sees a minimum number of EPM beneficiaries to be included on the list of EPM collaborators eligible for sharing arrangements. Further, in addition to the limits on the amount of gainsharing that providers may receive and the amount of repayment hospitals may offload to EPM collaborators, CMS should establish a maximum amount of reconciliation payments that hospitals may keep and, as a corollary, a minimum amount of gainsharing payments that must be paid to each collaborator. We believe these modifications will strengthen beneficiary choice and promote fairness, and we encourage CMS to consider these types of controls for these EPMs as well as for models going forward.

As a general matter, AGS encourages CMS to ensure far greater involvement of physicians and the professional societies that represent them in future efforts to design, evaluate, and implement EPMs. Additionally, we urge CMS to proceed carefully given the current lack of experience of specialized payment bundles for the frail and/or medical complex population. The current evidence base is limited and we recommend a careful and measured demonstration prior to further expansion and implementation. Additionally, there was no pre- post analysis of the sites which participated in the demonstration programs and there is no or limited evidence of a demonstration effect on process or outcomes measures. Hence, we ask that the implementation of EPMs be monitored carefully by CMS in the post- release stage to assure Medicare beneficiaries in fact receive the intended "better care, smarter spending, and better health". **We are also concerned that a mandatory program will burden small and rural providers, potentially restricting access to care and creating incentives to avoid admitting the frailest patients.**

While some of the current EPMs, such as the Oncology Care Model, were developed with significant input from the physician specialty societies, CMS has created significant new burdens for the entire healthcare system by proposing several mandatory programs that involve most of the providers in

a geographic area, with overlapping and sometimes conflicting requirements. AGS fears that confusion among providers will distract them from patient care as they try to understand and navigate the new rules of the episodes of care surrounding an acute myocardial infarction (“AMI”), coronary artery bypass graft (“CABG”), and surgical hip/femur fracture treatment excluding lower extremity joint replacement (“SHFFT”) while, at the same time, implementing the Quality Payment Program and meeting Stage 3 of Meaningful Use. **AGS urges CMS to implement a broad-based education campaign regarding the new EPMs that uses all of CMS’ communication channels to reach hospitals, post-acute care providers, physicians, and community-based providers of long term services and supports.**

Designing new EPMs is neither simple nor inexpensive, and AGS lacks the resources that would be required to propose new EPMs that would work better for geriatricians. Our members are committed to health system transformation, however. **AGS urges CMS to make more of its methodologies, data, and mathematical modeling not only transparent to the public, but digested and presented in ways that physicians can readily understand and grasp the implications for their practices.** Unfortunately, with the information provided AGS is unable to determine how our members would be affected by the Proposed Rule’s changes to the Comprehensive Joint Replacement (CJR) program and the addition of new EPMs for AMI, CABG and SHFFT. The impact analysis in the Proposed Rule is inadequate; CMS should make public far more data about how the agency expects different provider groups will be affected so that we can plan ahead.

Payment methodologies that are a “black box” do not give physicians useful signals about what actions they can take that will both improve quality of care for their patients and reduce costs at the same time, and will be unlikely to devote resources effectively towards those purposes. Without a more straightforward way for physicians to understand how their performance in APMs will be evaluated and what changes in practice would move them up or down, it will be difficult to improve the quality and value of care. Further, without adequate risk adjustment, physicians who treat the sickest patients will be penalized.

Further, some of our members have learned from experience that participation in such models can be financially disastrous for individuals and institutions, depending upon how the programs are designed and the benchmarks are set. AGS believes that EPMs require careful consideration using both clinical and economic experts and large databases. The AGS supports development of episodes that involve care of patients with chronic conditions. For those patients with multiple chronic conditions, we envision episodes that combine commonly co-occurring conditions but would continue to treat other less common chronic condition combinations separately. Involvement of the appropriate clinicians and specialty societies will be vital in determining which conditions could be combined and how that should occur.

AGS recommends that CMS examine whether the Hierarchical Condition Categories model would be a more appropriate way to measure the resource use of geriatricians as it could better account for comorbidity and provide a mechanism for risk adjustment. AGS also recommends that CMS specifically test the performance of the new EPMs on patients with multiple chronic conditions. Additional variables, such as performance of activities of daily living and presence of dementia, should be assessed.

C. Episode Definition for EPMs

Bringing (nearly) all relevant providers (excepting those excluded, mostly because they are in BPCI) into the same transformation incentive structure is a good idea. However, much of the potential benefit of cultural transformation that is possible in geographically-based reform is not worked into the current NPRM. The model envisions giving hospitals, skilled nursing facilities, home health agencies, physician groups, and others incentives to work together more effectively to ensure patients receive care in the most appropriate setting of care to achieve better outcomes more efficiently. However, CMS has not proposed infrastructure that would incentivize the process transformations that need to occur to achieve extensive cooperation, e.g. set up standardized forms and workflows, resolve questions of coverage for complications, and enhanced community-based services supports during the 90 days and at transition at the end. **AGS urges CMS to work with the QIOs to help providers in geographic areas work together to build infrastructure for care coordination activities, such as standardized forms, workflows, and processes for coordinating with community-based organizations.**

CMS could encourage this joint action through allowing cooperating geographic groups and by providing technical assistance through the QIO program (e.g., to help with data analyses, convening providers in the area, structuring implementation of improvement activities, monitoring tests of improvement, etc.) The Proposed Rule speaks to the need for CMS to provide summary reports to hospitals that do not have substantial analytic capability to handle raw claims, but having a QIO providing more explanation and customized analyses would be much more useful in many situations. CMS should encourage cooperation in the public interest and make fears of anti-trust action more manageable. Consider the possibilities if all hospitals in an area agreed to be measured by their total costs and quality because they aim to serve their community well. And whole vistas of potential gains open up – shared forms and workflows, optimizing rehabilitation quality, addressing supportive services needs in the community, and so on.

Further, AGS strongly believes that support for elderly and disabled persons requires integration of long-term care services and supports throughout the community, not just good medical care. The Proposed Rule does not adequately recognize the potential role of community-based organizations and supplemental services, and has no requirement to develop a patient-driven care plan or even to document issues and preferences. Many of the high-cost patients need social and supportive services in order to manage to stay reasonably well and out of the hospital – housing, food, caregiving, substance abuse harm reduction, transportation, and so forth. In the Community-Based Care Transitions Program and in other initiatives, the value of highly skilled community-based organizations in providing these services has come to be recognized and valued. **The final rule should provide for a serious role for community-based organizations, allowing them to be part of contracting and gain-sharing.** The NPRM mentions gain-sharing only with licensed health care professionals with home care agencies and hospitals providing the personnel. In light of their generally better expertise and proven track record, the social services components of the aging network in each community are probably better equipped and more efficient in doing these critical tasks, and they should be mentioned as full partners in the work in a final rule for this initiative.

AGS fears that the Proposed Rule's new EPMs will create access issues for these services, which will not be reimbursed under the model but are absolutely critical for supporting persons living with serious chronic conditions (who have a serious intercurrent episode, whether fracture or AMI). CMS should present much more comprehensive analytic work to understand the prevalence and needs of the

beneficiaries who have serious illness or disabilities prior to and during the episode and who therefore require substantial attention to the elements of comprehensive care and quality measurement that is tailored for these beneficiaries.

Patients with fractures or AMI in the context of serious disability, frailty, and concurrent illnesses have not benefitted from any substantial adaptation of the rules, the payments, or the quality measures. We cannot find definitive data as to the proportions involved, though CMS could do these analyses (and should do so and make the information public). These are populations that need comprehensive care plans, care teams, careful attention to every transition, goal setting, palliative care, and often substitute decision-making. They are also often in need of non-covered long-term care supports and services. They will have a much higher mortality rate, and we have no useful ways to risk-adjust for local patterns of care regarding end of life care in hospitals and in-patient hospice settings. A hospital that has traditionally served a substantial population of frail elders could be seriously disadvantaged and might seek to reduce its traditional commitment to this population in various ways, all of which are contrary to the interests of the frail elders. **AGS urges CMS to establish adequate measures to evaluate frail elderly beneficiaries' access to care planning, palliative care, long-term care services and supports, and behavioral health services.**

This mandatory bundling creates a new transition in care (at the end of the 90 days) for persons for whom the transitions are already so problematic. The transition into the hospitalization for serious conditions like these is obviously a quite disruptive event for those who had fractures or AMI. The rule should attend to this initial transition at least in the quality of care planning and the documentation of the decision to operate. So, the merits of the decision to hospitalize and to monitor or operate should have to be documented, both for fracture patients and for AMI. That documentation should show that risks and expected benefits have been honestly shared. At the end of the episode, the patient will probably lose whatever care coordination and supplemental benefits that the hospital was providing. This creates another transition, with the associated risks of inadequate information transfer, fear and anxiety in creating and learning another set of care arrangements, and cessation of important services. Persons with serious chronic conditions will not be stable and doing well at 90 days – they will be in fragile health and probably continuing to decline. The rule should require attention to these issues, probably generating quality metrics that track real performance in this transition. This would be an opportunity for CMS to tally utilization shortly after the 90 days. **CMS should generate and use metrics that directly monitor transition quality.**

CMS also must consider how to address attribution issues with a much greater degree of specificity than used in its various pay-for-performance initiatives to date. If a reliable and valid set of patient relationship codes is developed, these could be of great assistance in the attribution process. The AGS has some questions/reservations regarding the particular relationship codes defined in MACRA, and would also like to ensure that the codes do not create yet another administrative burden for physicians. CMS should continue its work on attribution methodologies, noting that there are many types of physician-to-physician relationships, particularly in a population of patients that is moving from a hospital to post-acute care to home: the medical director of the post-acute facility, the primary care physician, the hospital's staff physicians, anesthesiologists, surgeons, and specialists involved in the care of other chronic conditions. For example, CMS will need to consider relationships that physicians cannot currently code due to Medicare payment policies, such as indicating that they are a consulting or referral physician providing a report back to another physician. As also mentioned above, there should be some mechanism, at least in the APM setting, for physicians to indicate that they are the leader of a

multi-physician team, or are advising the patient's primary care physician, or are managing the patient's recovery following an acute episode.

We are also concerned that the CCJR model not create incentives for providers to avoid treating patients that would appear likely to be more costly or complicated to treat such as the complex, frail, older person with multiple comorbidities. CMS includes adverse selection of patients and other unintended consequences in the key questions it intends to consider in evaluating the model. We also urge CMS to keep this concern in the forefront of its decision making as it implements the proposed model and work to ensure that the model does not limit access to care for any beneficiary. We recommend that CMS describe the steps it has taken to prevent such adverse selection in the final rule.

We also urge CMS to conduct a robust evaluation of the CCJR model to determine whether these and other adverse incentives or unintended consequences are occurring. The change in referrals and care patterns, particularly if such change occurs abruptly, could affect the viability of other providers in the market such as SNFs and home health agencies. CMS should assess whether gains from achieving the reduced spending intended by the model are appropriately shared across providers affected by the demonstration and whether the model has the unintended consequence of reducing the availability of certain types of care within a community.

Finally, we are pleased that CMS has chosen outcome-focused measures on which to evaluate the quality of the care provided by participants in the CCJR model. **We urge CMS to continue to develop and use measures that reflect patient clinical outcomes and functional status following particular interventions or periods of care.**

J. Proposed Waivers of Medicare Program Requirements

AGS supports CMS' proposals to waive the direct supervision requirement for certain post-discharge home visits. The AGS supports CMS' proposal to adopt waivers of the telehealth originating site and geographic site requirement and to allow in-home telehealth visits for all three proposed EPMs, including a waiver to allow post-discharge nursing visits in the home. AGS was previously supportive of CMS' decision to waive certain program rules regarding the direct supervision requirement for certain post-discharge home visits, telehealth services, and the skilled nursing facility (SNF) 3-day rule under the CJR model.

We support CMS' efforts to allow these models the flexibility to provide care in the beneficiary's best interests that is not limited by the often outdated rules designed for the fee-for-service environment. In general, we urge CMS to adopt similar flexibility, including increased coordination of care and management of beneficiaries, in other projects and demonstrations testing payment reforms. The Independence at Home and Community-Based Care Transitions program have shown that visits at home are essential for medication management, detection of abuse or neglect, support of caregivers, and development of a workable care plan; and telehealth visits might well avoid in-person visits in many chronic care situations.

AGS supports the waiver of the SNF 3-day rule, and believes that it should apply to the CABG and SHFFT models in addition to the AMI model. Further, we urge CMS to implement the waiver on July

1, 2017, rather than delaying until April 1, 2018 so that providers have an opportunity to use the waivers before the measurement period begins for cost reconciliations.

AGS supports the waiver of beneficiary deductible and coinsurance that otherwise apply to reconciliation payments or repayments. **We urge CMS to modify its proposal so that beneficiaries are held harmless for non-covered SNF services for which they are referred by the originating hospital, regardless of whether a discharge planning notice is provided.**

AGS supports CMS' proposal to waive the billing requirements for global surgeries to allow the separate billing of certain post-discharge home visits, including those related to recovery from the surgery, but urges CMS in the Final Rule to clarify how this policy will interact with the proposal for 2017 to require billing G codes during the global period to collect information on post-surgical visits, if that proposal is finalized.

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The AGS greatly appreciates the opportunity to comment on proposals to improve the care of individuals with chronic and often complex conditions. Please do not hesitate to contact us, agoldstein@americangeriatrics.org, if we can provide any additional information or assistance.

Sincerely,

Nancy E. Lundebjerg, MPA
Chief Executive Officer