June 20, 2011

Donald M Berwick, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1518-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates

Dear Dr. Berwick:

The Advanced Medical Technology Association (AdvaMed) is pleased to submit the following comments on proposed changes to the Medicare hospital inpatient prospective payment system and FY 2012 rates (CMS-1518-P). AdvaMed member companies produce the medical devices, diagnostic products and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. AdvaMed members range from the largest to the smallest medical technology innovators and companies.

I. Proposed Adjustments for Documentation and Coding Changes

The proposed rule would make two separate adjustments to FY 2012 rates to recover what CMS considers to be overpayments for documentation and coding changes occurring in FYs 2008 and 2009. The net effect of these two adjustments is a reduction in the FY 2012 update of -3.15 percent.

The first adjustment is the remaining -2.9 percent non-cumulative adjustment that represents approximately one-half of the aggregate adjustment of -5.8 percent initially estimated by CMS to be required by law for recouping overpayments for FYs 2008 and 2009. In last year’s final rule, CMS implemented one-half, or 2.9 percent, of the estimated recoupment in FY 2011 and also indicated that it would implement the
remaining 2.9 percent reduction in FY 2012. In the proposed rule for FY 2012, CMS would move forward with the remaining -2.9 percent adjustment in FY 2012, but will remove the FY 2011 -2.9 percent adjustment in the FY 2012 base rate, since these retrospective adjustments are not cumulative. The rule notes that the -2.9 percent adjustment in FY 2011 was for one year only, and does not become part of the base amount. The net effect of these two changes will cancel each other out.

After further analysis of claims, CMS estimated that an additional -3.9 percent prospective adjustment was necessary for FYs 2008 and 2009 documentation and coding changes. For FY 2012, CMS proposes to apply a -3.15 percent prospective adjustment to partially offset the total -3.9 percent estimated adjustment required. CMS does not at this time propose a timeline to implement the remainder of this prospective adjustment.

AdvaMed continues to recommend that CMS reconsider the methodology it has adopted for separating documentation and coding effects from true case-mix change. AdvaMed believes that CMS has recovered excessive amounts for documentation and coding changes because of the methodology it has used. AdvaMed also recommends that CMS test a range of regression models to estimate changes in documentation and coding. In addition, CMS should supplement claims data analysis with medical records analysis for distinguishing documentation and coding from real case-mix changes, in order to ensure accuracy in its estimates of both case-mix and documentation and coding changes.

Once CMS has determined an accurate level of adjustments necessary to offset documentation and coding changes, AdvaMed further recommends that CMS phase in the prospective adjustment with more equal reductions over a longer period of time. In contrast to this approach, CMS has chosen to front load its recommended 3.9 percent prospective adjustment by proposing to reduce rates 3.15 percent in FY 2012. This approach results in another average negative update for IPPS hospitals, following a negative update for FY 2011. If CMS had instead proposed a longer and more gradual phase-in of the adjustment, hospitals could have a positive, albeit small, average update, at a time when MedPAC projects negative Medicare margins of 7 percent.

II. New Technology Add-On Payments

AdvaMed continues to be concerned with the stringency of CMS’s criteria for new technology add-on payments and the chilling effect we believe they have had on the number of applications submitted for consideration. Only three applications will be considered for add-on payments for FY 2012.

Uncertainties in reimbursement for new medical technologies create disincentives for companies, regardless of size, to invest in research and development that lead to medical technology innovation and improvements in the quality and efficiency of health care. Small venture capital funded firms are particularly vulnerable to these uncertainties, because, even if they have FDA approval, they are dependent on coverage and payment policies of public and private payers. These small companies are particularly critical to U.S. technology leadership, because they are the source of so many of the breakthrough
technologies that drive medical technology innovation. What is at stake is continued medical progress and access of Medicare beneficiaries and other patients to care that can improve their health outcomes and well-being.

A contributing factor to the lack of approvals for new technology add-on payments has been the requirement by CMS that new technologies show evidence of clinical benefit in randomized clinical trials with outcomes. Since by definition the technology must be new, and less than 3 years old, it is extremely unlikely, or in some cases, impossible to have long-term outcomes results. The new technology add-on payment, which covers only part of the cost, and is temporary, should not require the same level of evidence provided through long-term outcomes studies. Evidence of the benefit of the new technology in case reports citing positive outcomes in individual patients should be sufficient for approval of an add-on payment for a promising new technology.

As we noted in our statement at CMS's New Technology Town Hall meeting February 2, 2011, AdvaMed is pleased with CMS's decision to add a third factor to its evaluation of whether a new technology is substantially similar to one or more existing technologies, and specifically to consider whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population.

AdvaMed continues to recommend additional improvements to current policy for new technology add-on payments in light of the importance of patient access to innovative technologies. These improvements should include:

- Lowering the current cost threshold required to trigger the add-on payment;
- Increasing the amount of the add-on payment, e.g. from 50 to 80 percent, so that it covers a larger share of estimated new technology costs;
- Allowing major incremental improvements in technologies (e.g., a battery that lasts 10 years rather than 5) to meet the test that the technology is new;
- Allowing a broader range of evidence to be considered in assessing whether a new technology meets the test of providing substantial clinical improvement over an older technology; and
- Allowing the "substantial clinical improvement test" to be met if there is substantial likelihood that clinical improvement will result.

By our calculations, CMS has approved only 8 applications for new-tech add-on payments since 2005. It is critical for CMS to maintain and improve incentives for hospitals and other providers to provide beneficiary access to innovative technologies. The new technology add-on payment and the assignment of new technologies to analogous, appropriate MS-DRGs are critical for maintaining and improving access to innovative technologies.
III. Charge Compression

AdvaMed has strongly supported improvements to the accuracy of weights based on estimated costs. AdvaMed has also supported CMS’s proposal to address the problem of charge compression by establishing two separate cost centers in the Medicare cost reports, one for medical supplies and a second for implantable devices, and to define the cost centers based on the use of existing revenue codes and associated definitions.

AdvaMed was disappointed to learn in the proposed rule that only 437 hospitals had completed the “Implantable Devices Charged to Patients” cost center. This clearly points to the need for CMS to undertake additional outreach and educational activities in order to ensure that cost report changes are implemented effectively and accurately. These educational activities should go beyond the distribution of bulletins that are used to inform providers about changes to the Medicare program. We anticipate that additional educational efforts will lead to more hospitals completing the implantable device cost center, and at the same time, improve the validity of weights based on estimated costs.

AdvaMed asked its consultant, Direct Research, LLC, to determine if more current information were available about the number of hospitals using the implantable device cost center since the time when CMS produced its analysis for the proposed rule. Using cost reports from an April 2011 update of HCRIS, Direct Research found nearly 800 hospitals using the new cost center. Furthermore, Direct Research estimates that 1,000 hospitals will be using the new cost center by the time CMS must finalize the FY 2012 rule, based on the observation that roughly half of newly-filed cost reports have information in the new cost center. In the proposed rule, CMS states that it would not be using data from the implantable device cost center to create a distinct cost-to-charge (CCR) ratio for use in calculating the FY 2012 MS-DRG relative weights because so few hospitals were using the cost center. AdvaMed recommends that CMS reconsider this decision since more recent analysis of HCRIS points to a significantly larger number of hospitals using the cost center by the time CMS must finalize the rule. If that is the case, AdvaMed recommends that CMS use data from the cost center for reweighting the MS-DRGs for FY 2012.

In addition to recommending that data from the implantable device cost center be used for reweighting the MS-DRGs as early as FY 2012, AdvaMed continues to argue, as we did two years ago, that CMS take actions to monitor the accuracy of data reporting under the new implantable device cost center. One such strategy that CMS could use for this purpose would be to require that Medicare Administrative Contractors (MACs) develop an audit program for ensuring the validity of data reported for both medical supplies implantable devices. As part of this audit program, MACs could also require hospitals to explain what they had not reported data for the new cost center. Another approach would be for CMS to require that cost reporting software be modified to increase to a level 1 error instances where information reported for line 64 of Worksheet was not consistent with the absence of data reported for implantable devices.
IV. IPPS Recalled Device Policy Clarification

The proposed rule includes a proposal for clarifying the IPPS policy on Medicare’s payment reduction for certain MS-DRGs when the hospital receives from a manufacturer a credit equal to 50 percent or more of the cost of the device. CMS proposes to conform the IPPS policy to the OPPS policy and to clarify that reductions to IPPS payments for certain MS-DRGs will only be applied when a hospital receives a credit equal to 50 percent or more of the cost of the replacement device. The policy to reduce IPPS payments to hospitals receiving device credits has never clarified whether the credit should be based on the replacement device or the original device. AdvaMed supports CMS’s proposed clarification and believes that CMS should have parallel policies on this issue for both inpatient and outpatient hospital settings.

V. Hospital Readmission Reduction Program

In the proposed rule, CMS puts forward readmission measures for three conditions, Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN) to be used for the Hospital Readmission Reduction Program, under which payments to certain hospitals will be reduced to account for excess readmissions. This directs CMS to exclude from the measures readmissions that are unrelated to the prior discharge, such as planned readmissions and transfers. CMS proposes to implement the readmissions reduction program over two years. In the proposed rule, CMS discusses the conditions and readmissions to which the program would apply in the first year, the measures and methodology used for those measures, and the public reporting of the readmissions data. CMS plans to discuss the provisions regarding the payment adjustment in next year’s inpatient IPPS rule.

CMS proposes, without modification, the following readmission measures:
- Acute Myocardial Infarction (AMI) 30-day Risk Standardized Readmission Measure (NQF#0505)
- Heart Failure (HF) 30-day Risk Standardized Readmission Measure (NQF#0330); and
- Pneumonia (PN) 30-day Risk Standardized Readmission Measure (NQF#0506)

CMS is proposing to adopt the measures and related methodologies as they are currently endorsed by NQF. Although all three have been endorsed by the NQF, only one of these measures, AMI, contains some minimal exclusion criteria for readmission, namely exclusion for some planned readmissions related to percutaneous transluminal coronary angioplasty (PTCA) and coronary artery bypass graft procedures (CABG).

The other two measures, dealing with heart failure and pneumonia, do not contain exclusion for diagnostic measures of readmission. It is noted that during the development of the Inpatient Quality Reporting (IQR) measures, clinical experts did not identify planned procedures as occurring commonly after admissions for HF or PN, and as a result, no exclusions were proposed or applied for these diagnostic measures of readmissions.
These proposed readmission measures do not contain wide-ranging exclusions for readmissions that are unrelated to the prior discharge. Considerations of these exclusions are invaluable in developing a consistent and credible readmission reduction program. In developing this important program, CMS should keep in mind that many readmissions are clearly beyond a hospital’s control and that these facilities may not be accountable in some of these cases. In the proposed rule, CMS states that there are no “clinically and technically sound and accepted strategies for accurately identifying readmission that are unrelated to hospital quality based on the documented cause of readmission”, however, we understand that there are State public reports which are based on a readmission measure that contains comprehensive exclusions for unrelated readmissions.\(^1\)

With regard to the three proposed readmission measures, the exclusion for planned readmission for cardiac catheterization following AMI is very reasonable; however it is far too limited. In the case of heart failure, especially in patients with severe disease, several readmissions may be contemplated, for example placement of heart defibrillators, angioplasty, and surgeries such as bypass grafts or, in rare instances, heart transplants. In the case of pneumonia -- depending upon the type, cause and underlying condition (e.g., coronary disease) -- there are several potentially planned readmissions circumstances which could be foreseen, including planned readmissions for contemplated treatment/surgery post resolution of the pneumonia.

When considering these exclusions, aside from considering planned readmission, it is crucial that CMS consider what entities may be considered unrelated to prior discharge. Many of the Medicare patient population -- especially those hospitalized with Heart Failure, Heart Attacks or Pneumonia -- have multiple co-morbidities. These serious co-existing conditions, such as autoimmune diseases including myasthenia gravis, multiple sclerosis or rheumatoid arthritis or other conditions such as long-standing atherosclerotic-related conditions, pancreatitis, cholecystitis, diverticulitis, inflammatory bowel disease or gout to name a few, may have no clinical relationship to the reason for the index admission. These conditions can occur or “flare-up” unpredictably and are not preventable under most circumstances. It is essential that any hospital readmission reduction program not inadvertently mischaracterize the reason for hospitalization admissions and penalize index hospitals inappropriately.

AdvaMed recommends the following regarding the proposed readmissions program. **AdvaMed strongly suggests that CMS review the proposed readmissions measures in detail and provide a comprehensive set of planned and unrelated readmissions conditions for each proposed readmission measure sets.** Patients with certain conditions which, by their very nature, necessitate potential readmissions such as trauma, cancer, end-stage diseases, for example, end stage renal disease, rehabilitation patients, and others should be excluded from readmission measures. **Also, AdvaMed suggests that CMS consider initiating a modifier code on the hospital claims forms which specifically would indicate a planned readmission.** Ignoring many of these issues

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which are necessary to provide a credible readmission program containing accurate readmissions criteria may have the unintended consequence of misrepresenting hospital quality performance. Even worse, this could negatively affect patient care at some hospitals which may become more focused on weighing the readmission potential subsequent to each admission and choose to defer or refuse to admit a patient and alternately elect to place them in a holding area, ambulatory setting or other non-admission status. By providing a more comprehensive approach and including many of the suggestions above, CMS can provide hospitals with the tools that they need to decrease readmissions while trying to improve quality of care for patients.

AdvaMed strongly urges CMS to consider the serious unintended consequences that may be associated with the development and implementation of the proposed readmission (and efficiency measures discussed below) including:

1) Patients prematurely discharged without appropriate follow-up which could potentially mask negative outcomes occurring outside the episode of care;

2) Providing measures that do not reflect the variety of settings to which a patient is discharged or the care actually received in that setting;

3) Patients experiencing limited access to the physicians, and other health care providers with appropriate medical/clinical expertise to treat their specific conditions; and

4) Providers avoiding certain types of patients, namely those patients who are more ill/complicated and more medically challenging.

If situations like these occur in significant numbers, patient outcomes will be lower than would have been otherwise possible, hospital readmissions may ultimately inadvertently increase, and the emergency department (ED) admissions could dramatically increase unintentionally. Accordingly, AdvaMed strongly suggests that the criteria and rules developed in these proposed program should be monitored and reviewed for these and other potentially other problematic scenarios.

VI. Efficiency Measure: Medicare Spending Per Beneficiary

CMS has proposed to add a new measure to the Hospital IQR Program for the FY 2014 payment determination: Medicare Spending per Beneficiary. The ACA requires that CMS incorporate efficiency measures, including measures of Medicare spending per beneficiary, by 2014. AdvaMed urges CMS to withdraw its proposed measure at this time, however, for the reasons outlined below.

First, CMS notes in the proposed rule that it is not aware of the NQF or any other consensus organization currently endorsing any Medicare spending per beneficiary measures. Given the complexity of this approach and the other issues raised below, we believe it is particularly critical that CMS not proceed with adopting such a measure prior
to a measure undergoing NQF’s consensus-based endorsement process. This is particularly the case given that the NQF currently has a project underway to review efficiency measures, and this process should be completed in sufficient time for an NQF-endorsed measure to be available for 2014 payment. This process is best suited to fully evaluate the many technical issues that need to be considered prior to adopting an efficiency measure.

Second, the proposed rule gives no indication that CMS is proposing a measure that has been sufficiently field-tested. As a result, questions arise about the validity of the proposed approach. For example, CMS proposes to use the hierarchical condition categories (HCCs) to adjust for severity of illness. Although the HCCs have been used to account for patient severity over an extended period of time, it is not clear how well they predict patient severity following an acute hospitalization, potentially unrelated to any ongoing conditions measured by the HCC.

Third, proposing this broad-based efficiency measure for all hospital discharges appears overly-ambitious relative to the more targeted efforts to reduce preventable readmissions and bundle post-acute payments that were included in the Affordable Care Act. These policies are disease specific, with the authority granted to expand beyond the additional list after a few years.

Fourth, the proposed rule describes adjustments to the payment calculations for geographic adjustors and some payment adjustments under the IPPS, but no mention is made of add-on payments for new technology or OPPS payments (including those for new technology add-ons or drug pass-through payments). A new technology may offset drug or post-acute care utilization and if certain benefits are not captured, it will systematically bias the resource utilization measures and the efficiency measures. In considering efficiency measures, it is necessary to have complete data on all encounters with the health care system, including pharmacy, which will better estimate the true value of particular health care interventions or therapies. Additionally, we believe that it is important that CMS consistently articulate the need to combine resource-use/efficiency measures with clinical outcomes measures to fully capture and effectively measure efficiency.

In developing these efficiency measures, CMS should bear in mind that resource use must be determined over an appropriate episode of care, which includes a sufficient period of time to assess the overall value of the services provided. We believe that it only makes sense for efficiency — and measures dealing with efficiency — to be defined to include the overall value of the service, including both quality and cost. One could easily draw erroneous conclusions about the relative value of care if an inappropriate time period is used. For example, a provider may have a choice between a lower-cost medical device which is expected to need replacement within a few years, necessitating another hospitalization, and a higher-cost device which will last many more years. If resource use, or costs, are measured based on an episode of care that only considers the hospitalization and perhaps a 90-day period post-discharge, the “total” cost of the episode may appear on its face to be a better value because the initial cost of the device was
lower. However, this assessment would be inaccurate as it would not consider the additional costs associated with a subsequent readmission, surgical costs and device replacement costs that could have been delayed or avoided if the higher-cost, longer lasting device was initially chosen. Even a one-year period might be insufficient to assess the value of many new technologies to patients and/or the health care system overall.

AdvaMed also suggests that CMS adjust for more factors than the finite set proposed. For example, specialized hospitals, such as those concentrating on cardiac or orthopedic conditions -- two areas that have a high number of Medicare beneficiaries -- may, by the very nature of care provided, have an inherent high cost per beneficiary. Socioeconomic status (SES) is also an important factor which can contribute to costs (see discussion under Readmissions Measures). Negating these factors may introduce unintended bias and invalidate the results. If implemented as proposed, the measure may inadvertently compel hospitals to avoid high risk patients in order to increase their performance scores. As such, urban hospitals -- especially teaching hospitals which generally treat sicker and more costly patients -- may be penalized, even though the quality of care may be adequate. For all these reasons, AdvaMed believes the proposal for assessing Spending Per Beneficiary should be withdrawn at this time, until the NQF has completed its review process for endorsement of efficiency measures.

1. Risk Adjustment Concerns For Both Readmissions and Spending Per Beneficiary Measures

AdvaMed also has some concerns regarding the proposed risk-adjustment methodologies for both the readmissions and Spending Per Beneficiary Efficiency Measure. AdvaMed wishes to emphasize the importance of considering risk adjustment factors in the development and implementation of both proposed measure sets. Risk adjustment is a key element that must be valid, reproducible, sensitive and specific. Any flaws that may be present in the methodology to examine risk adjustment can potentially lead to flawed conclusions and therefore compromise the validity of the resultant conclusions. Thus it is important to consider as many relevant variables as possible in developing these models. In addition to age, sex, race, severity of illness and clinical covariates, socioeconomic status, other concurrent treatments/interventions and their associated intensity/complexity and sources of co-morbidity should also be considered. The potential side effects and adverse reactions associated with the different therapies and interventions that may occur to patients may also need to be considered. Notably absent from many discussions on determination of risk stratification factors are individual patient measures such as functional status or ability to ambulate/range of motion. AdvaMed strongly believes that these patient-specific factors should be included in the risk stratification for these measures, as they vary from patient to patient and can play a very significant role in contributing to outcome measurements, potential readmissions and estimated costs, especially in the post-surgical setting.

AdvaMed strongly believes that risk stratification should take into account a patient’s socioeconomic status. AdvaMed recognizes that SES-based information, for example, educational level, literacy and language skills/abilities, can potentially alter the
process of care of patients undergoing hospitalization and thus confound the results and conclusions in these measure sets. For example, some patients, while they may be literate, may not understand the complexity of their health condition and their care and treatment. This will influence their compliance and ultimately can significantly impact the quality of care that they receive which, in turn, will affect any outcome data, as well as the potential for readmissions and costs. Additionally, there may be some hospitals where SES would have a significantly different impact on complication or readmission rates (e.g., hospitals in regions for which patient SES is incongruent with the average of all U.S. hospital regions). We believe that while this information may be difficult to elicit and collect, its omission could have a significant impact on the validity of these measures.

VII. Hospital Inpatient Quality Reporting (IQR) Measures

In the FY 2011 IPPS final rule, CMS finalized a three-year plan for expanding the quality measures required under the Hospital IQR Program for the FY 2012, FY 2013 and FY 2014 payment determinations. In this rule, CMS proposes to modify the measure set for the FY 2014 payment determination that was finalized in last year’s rulemaking, and for the first time proposes a measure set for the FY 2015 payment determination.

A. IQR FY 2014 Proposals

1. New/Retired Measures

For FY 2014, eight measures would be retired and 4 new measures would be added, including a measure of Medicare Spending per Beneficiary. These 8 retired measures are also among those measures that CMS chose not to include in the FY 2013 Hospital Value Based Purchasing Program measure set under the proposed rule published on January 13, 2011 (76 FR 2454). In all but one case, CMS has concluded that the measures are “topped out,” that is, hospital performance is uniformly high nationwide. The seven topped out measures CMS proposes to retire are: AMI-1 Aspirin at arrival; AMI-3 ACEI/ARB for left ventricular systolic dysfunction; AMI-4 Adult smoking cessation advice/counseling; AMI-5 Beta-blocker prescribed at discharge; HF-4 Adult smoking cessation advice/counseling; PN-4 Adult smoking cessation advice/counseling; and SCIP INF-6 Appropriate Hair Removal.\(^2\) **AdvaMed understands the proposed exclusion of topped out measures from public reporting, however we caution CMS to continue to monitor the potential need to include any of these measures in a future time, should there be indications that there is not consistent high uniform performance nationwide.**

The four measures include two (2) healthcare-associated infection (HAI) measures, a measure of Medicare spending per beneficiary episode, and a measure regarding participation in a clinical database registry for general surgery. The first measure is

\(^2\) The additional measure proposed for retirement is pneumonia measure PN-5c, “Timing of receipt of initial antibiotic following hospital arrival”, which CMS believes would result in the unintended consequence of inappropriate antibiotic use.
Central Line Insertion Practice Adherence Percentage (CLIP), which assesses the extent to which a facility employs practices consistent with CDC Healthcare Infection Control Practices Advisory Committee (CDC/HICPAC) recommendations that are known to reduce central line blood stream infections. The second measure is Catheter Associated Urinary Tract Infection (CAUTI). Both measures have been endorsed by the National Quality Forum (NQF), however, CMS notes that the CAUTI measure is undergoing measure maintenance review at NQF which may result in a change to the specifications. **AdvaMed is pleased that these two proposed measures have been previously NQF endorsed, but regarding the CAUTI measure, cautions CMS to wait until NQF has finished their on-going maintenance review of the measure before implementation.**

### B. IQR FY 2015 Proposals

For FY 2015, in addition to continuing the measures proposed for FY 2014, CMS proposes to add three additional HAI measures, and two sets of chart-abstracted measures: a stroke measure set and a (Venous Thromboembolism) VTE measure set.

#### 1. Stroke/Venous Thromboembolism (VTE) Measure Sets

CMS proposes to add a stroke measure set consisting of eight (8) process of care measures, and a venous thromboembolism (VTE) measure set, consisting of six (6) measures, to the Hospital IQR Program for the FY 2015 payment determination. CMS noted that both measure sets are NQF endorsed. **AdvaMed supports the inclusion of the measure sets in the IQR program.**

### C. Possible New Future Quality Measures

In the proposed rule, CMS indicates its intention to propose in future rules the addition of outcome measures for stroke and joint replacement surgery. These measures have been developed by CMS and they anticipate submitting them for NQF review. In addition, as additional HAI measures gain NQF endorsement, CMS will propose their addition to the Hospital IQR Program measure set. **AdvaMed applauds CMS for submitting future proposed measures for review and endorsement by NQF. In addition, we believe that wound care measures and malnutrition evaluation measures, if endorsed in the future by NQF, should be added to the IQR.**

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implementation, those related to the prevention and control of healthcare-associated infections (HAIs) should continue to be a first-line priority.

If you have any questions or comments please contact Richard Price at (202)434-7227 or rprice@advamed.org.

Sincerely,

[Signature]
Ann-Marie Lynch