Attachment 1a - DLTSS Meeting Agenda 1-22-15

VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, January 22, 2015; 10:00 PM to 12:30 PM

4th Floor Conference Room, Pavilion Building

109 State Street, Montpelier

Call-In Number: 1-877-273-4202; Passcode 8155970

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:10	**Welcome; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from December 4, 2014	Yes
2	10:10 - 11:00	**VT Department of Mental Health Surveys and Findings for Adults and Children** Tyler Blouin and Sheila Leno	• Attachment 2: CRT and Kids Survey Presentation	
3	11:00 – 11:45	**Updates:** • **Frail Elders proposal – Georgia Maheras** • **DLTSS Work Group Letter to the Governor** • **Follow-up from December 4 Work Group meeting** • **VHCIP Evaluation Survey**	• Attachment 3a: Frail Elders proposal January 2015 • Attachment 3b: DLTSS Work Group Letter to the Governor	
4	11:45 – 12:00	**Public Comment/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: Thursday, February 19th 10:00 am - 12:30 pm in Montpelier	

Attachment 1b - DLTSS Meeting Minutes 12-04-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Thursday, December 4, 2014, 10:00 pm – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1. Welcome; Introductions; Approval of Minutes	Deborah Lisi-Baker welcomed the group and sought approval of the November 21, 2014 meeting minutes which were approved.	
2. Population Health Work Group Presentation	Tracy Dolan, Acting VDH Commissioner and Karen Hein, MD presented on the recent work of VHCIP's Population Health Work Group (PHWG) and their recommendations on ways to incorporate population health improvement and social determinants of health into VCHIP activities and results. Highlights of their presentation included plans to develop a public health plan for Vermont that focuses on building systemic capacity to promote public health, aligning health expenditures to social determinants of health, and recommending adoption of performance measures and financing models that will help Vermont eliminate or reduce health disparities and build shared accountability for improving the health of all Vermonters. The PHWG is promoting support for prevention initiatives and greater integration of clinical services, public health programs and community-based services. The presentation included "frameworks" to guide Population Health and a summary of the known contributors to health outcomes. Following the presentation, topics discussed included Accountable Health Communities, the importance of mental health, discussion of the concept of a health budget for the State, and the importance of community health needs assessments.	

Agenda Item	Discussion	Next Steps
3. ACOs and the DLTSS System -- Questions Posed by VT Legal Aid and VCDMHS with Responses from ACOs	Work Group participants included providers, ACOs, advocates and others who engaged in an in-depth discussion of the DLTSS system of care as it relates to ACOs and the State. The overall focus of the discussion was to build upon the existing system as we form partnerships to improve care and outcomes for Vermonters with DLTSS needs. **Please refer to Attachment 3 for the ACOs' written responses to questions 1-7. Questions 1-4 were discussed at the November 21, 2014 DLTSS Work Group meeting and documented in the minutes from that meeting.** **<u>Discussion Highlights for Questions 5-7:</u>**	
<u>Question 5</u> **Have any of the ACOs adopted new care management protocols or standards internally (while waiting on the Care Models/Care Management workgroup) that establish different expectations of DLTSS case managers than those in their existing roles?**	OneCare stated its commitment to the Care Management Standards being created by the VHCIP CM/CM Work Group. CHAC is oriented toward community partnerships with DLTSS providers with a focus on collaboration. Participants encouraged PCPs to have greater knowledge of the DLTSS system, and DLTSS providers to have a better understanding of the role of primary care practitioners. It is hoped that the Integrated Communities Care Management Learning Collaborative will achieve that goal. One of the most important elements is "effective communication" among the different domains.	
<u>Question 6</u> **How will DLTSS providers manage to meet operational, financial and quality expectations of multiple ACOs and at the same time meet these**	Participants felt the challenge of multiple ACOs with varying sets of expectations needs to be addressed locally by ACOs working in concert with one another. There is a desire for alignment of expectations among ACOs and this work has already begun. The Blueprint is working on the concept of regional collaboration to represent the array of providers. Regional collaboration efforts are especially important given that not all Vermonters are attributed to an ACO. (The DLTSS Work Group agreed this is a topic for future conversations.) The ACOs can provide advice and counsel but funding is not available.	

Agenda Item	Discussion	Next Steps
expectations for individuals who are not covered by the ACOs (because they do not see an affiliated primary care physician) whose funding continues to come through AHS and its Departments?		
<u>Question 7</u> **Will disability and long term services and supports (DLTSS) providers have sufficient voice in the governance and operation of ACOs? How will this voice be operationalized?**	OneCare has a statewide multidisciplinary Clinical Advisory Board; however, it is primarily a medical/clinical group with representation from other provider groups. OneCare will provide a list of its Clinical Advisory Board members to the DLTSS Work Group. OneCare has three consumer representatives (beneficiaries of Medicare, Medicaid, and Commercial-Health Exchange) on its Board.	
4. Update on the All-Payer Waiver and the Consolidated Global Commitment Waiver	The ACA put into place options for new waivers, one of which is the 1332 Waiver for development of universal coverage. The other is an All-Payer Waiver which is focused on payment methodology for better alignment between Medicare, Medicaid and commercial payers. One primary goal of the All-Payer Waiver would be a reduction in the variation of payment by payers and a resulting decrease in the cost shift. The All-Payer Waiver would not allow Vermont to control Medicare funding. Pursuit of waivers is contingent upon being a "good deal" for Vermont. The Consolidated Global Commitment (GC) Waiver entails consolidating two separate but similar waivers (Global Commitment and Choices for Care) into one Waiver for administrative simplification and streamlining of Federal reporting requirements. The Consolidated Global Commitment Waiver would be embedded in the All-Payer and 1332 Waivers. An in-depth	

Agenda Item	Discussion	Next Steps
	presentation on the Consolidated GC Waiver will be given to the DLTSS Work Group once the Waiver is signed by Vermont and CMS. The current target date for signature is January, 2015.	
5. DLTSS Work Group letter to the Governor	The Work Group discussed the draft letter to the Governor and voted 9 to 4 to support it (with 1 abstention). Supporting points were that the DLTSS Work Group should formally support funding for DLTSS services during the Fiscal Year 2015 budget adjustment and Fiscal Year 2016 budget development process, Medicaid funding reductions of DLTSS services would lead to higher health care costs systemwide, and reductions in funding would have adverse impacts on vulnerable individuals. Opposing points were that this kind of activity was not part of the DLTSS Charter, the letter itself was too detailed, the letter needed to clearly state that State employees were excluded, and concern over the limited 24-hour comment period. The VHCIP review process for this letter could extend through early February given it would need to go to the Steering Committee and Core Team prior to final approval. It was announced that members of the DLTSS Work Group could send a separate letter to the Administration from individuals and organizations and not as a product of the DLTSS Work Group.	
6. Public Comment Updates/Next Steps	**The next meeting will be held on Thursday, January 22nd, 10:00 am – 12:30 pm in Montpelier on the 4th Floor of the Pavilion Building.**	

VHCIP DLTSS Work Group Member List

Roll Call: 12/4/2014

Member		Member Alternate		Minutes		
First Name	**Last Name**	**First Name**	**Last Name**			**Organization**
Debbie	Austin	Craig	Jones			AHS - DVHA
Molly	Dugan					Cathedral Square and SASH Program
Patrick	Flood					CHAC
Mary	Fredette					The Gathering Place
Joyce	Gallimore					Bi-State Primary Care/CHAC
Larry	Goetschius	Joy	Chilton			Home Health and Hospice
Dale	Hackett					None
Mike	Hall					Champlain Valley Area Agency on Aging
Jeanne	Hutchins					UVM Center on Aging
Pat	Jones	Richard	Slusky			GMCB
Dian	LaShay					Consumer Representative
Deborah	Lisi-Baker					Unknown
Sam	Liss					Statewide Independent Living Council
Jackie	Majoros	Barbara	Prine			VLA/LTC Ombudsman Project
Carol	Maroni					Community Health Services of Lamoille Valley
Madeleine	Mongan					Vermont Medical Society
Todd	Moore					OneCare Vermont
Kirsten	Murphy	Julie	Wasserman			AHS - Central Office
Nick	Nichols					AHS - DMH
Ed	Paquin					Disability Rights Vermont
Laura	Pelosi					Vermont Health Care Association
Eileen	Peltier					Central Vermont Community Land Trust
Judy	Peterson					Visiting Nurse Association of Chittenden and Grand Isle Counties
Paul	Reiss	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Rachel	Seelig	Trinka	Kerr			VLA/Senior Citizens Law Project
Julie	Tessler	Marlys	Waller			Vermont Council of Developmental and Mental Health Services
Nancy	Warner					COVE
Jason	Williams					Fletcher Allen Health Care
Marie	Zura					HowardCenter for Mental Health
			8			

VHCIP DLTSS Work Group Participant List

Attendance: **12/4/2014**

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	DLTSS
April	Allen		AHS - DCF	X
Susan	Aranoff	[illegible]	AHS-DAIL	X
Debbie	Austin		AHS - DVHA	M
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Susan	Besio	here	SOV Consultant - Pacific Health Policy Group	X
Bob	Bick		HowardCenter for Mental Health	X
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman		HowardCenter for Mental Health	X
Joy	Chilton		Home Health and Hospice	MA
Amanda	Ciecior		AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	X
Amy	Coonradt		AHS - DVHA	X
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper		AHS - DVHA	X

Molly	Dugan	[signature]	Cathedral Square and SASH Program	M
Patrick	Flood		CHAC	M
Erin	Flynn		AHS - DVHA	S
Mary	Fredette	phone	The Gathering Place	M
Joyce	Gallimore	phone	Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Larry	Goetschius		Home Health and Hospice	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Dale	Hackett		None	M
Mike	Hall		Champlain Valley Area Agency on Aging	M
Janie	Hall		OneCare Vermont	A
Bryan	Hallett		GMCB	X
Carolynn	Hatin		AHS - Central Office - IFS	X
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Churchill	Hindes	[signature]	OneCare Vermont	X
Jeanne	Hutchins	here	UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones	phone	GMCB	M
Margaret	Joyal		Washington County Mental Health Services Inc.	X
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	MA
Tony	Kramer		AHS - DVHA	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Dion	LaShay	phone	Consumer Representative	M
Deborah	Lisi-Baker	[initials]	Unknown	C/M
Sam	Liss		Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
Georgia	Maheras	here	AOA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	M
Carol	Maroni		Community Health Services of Lamoille Valley	M
Mike	Maslack			X

Lisa	Maynes		Vermont Family Network	X
Madeleine	Mongan	phone	Vermont Medical Society	M
Todd	Moore		OneCare Vermont	M
Mary	Moulton		Washington County Mental Health Services Inc.	X
Kirsten	Murphy		AHS - Central Office - DDC	M
Floyd	Nease		AHS - Central Office	X
Nick	Nichols		AHS - DMH	M
Miki	Olszewski		AHS - DVHA - Blueprint	X
Jessica	Oski		Vermont Chiropractic Association	X
Ed	Paquin	Ed Paquin	Disability Rights Vermont	M
Annie	Paumgarten	phone	GMCB	X
Laura	Pelosi		Vermont Health Care Association	M
Eileen	Peltier		Central Vermont Community Land Trust	M
Judy	Peterson		Visiting Nurse Association of Chittenden and Grand Isle Countie	C/M
John	Pierce			X
Luann	Poirer		AHS - DVHA	X
Barbara	Prine	here	VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
Ken	Schatz		AHS - DCF	X
Rachel	Seelig	here	VLA/Senior Citizens Law Project	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	MA
Kara	Suter		AHS - DVHA	X
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler	here	Vermont Council of Developmental and Mental Health Services	M
Bob	Thorn		Counseling Services of Addison County	X
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Anya	Wallack		SIM Core Team Chair	X
Marlys	Waller		Vermont Council of Developmental and Mental Health Services	MA
Norm	Ward		OneCare Vermont	X
Nancy	Warner		COVE	M
Julie	Wasserman	here	AHS - Central Office	S/MA
Kendall	West			X

Bradley	Wilhelm		AHS - DVHA	X
Jason	Williams		~~Fletcher Allen Health Care~~ UVM Medical Center	M
Cecelia	Wu		AHS - DVHA	X
Marie	Zura		HowardCenter for Mental Health	M
				86

Beverly Boget VNA of CHGI

Heidi Klein phone

Attachment 2 - CRT and Kids Survey Presentation

VT Department of Mental Health
Surveys and Findings for Adults and Children

Tyler Blouin, MA
Chief of Research and Statistics

Sheila Leno, MS
Lead Mental Health Analyst

Vermont Department of Mental Health
Research & Statistics Unit

Background of Surveys

Purpose

- To monitor Community Rehabilitation and Treatment (CRT) program performance and children and adolescent mental health program performance from the perspective of service recipients

History

- Previous surveys of consumers in CRT programs took place in 1997, 2001, 2003, 2006-2013
- CRT survey now administered annually
- Previous surveys of Parents of consumers in children and adolescent mental health programs took place in 2002, 2006, 2008, 2010, and 2012
- Previous surveys of consumers in children and adolescent mental health programs took place in 1999, 2003, 2007, 2009, 2011, and 2013
- Parent and Children surveys now alternate years

Development

- Survey based upon Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey and the Youth Services Surveys (MHSIP)
  - Differences between Vermont version and MHSIP version
    - Present vs. past tense
    - Additional questions

Background of CRT Survey

Administration

- State staff send out mailings, receive surveys, enter results, and analyze findings

Funding

- General budget
- Level of effort considered for SAMHSA contract

Presenting Survey Findings

- Technical and executive summary posted on DMH website
- Executive summary presented as a performance indicator project (PIP) report
- Results presented in Act 79 annual report
- Results used in Uniform Reporting System (URS) to NRI/SAMHSA

Survey Methodology

Survey Construction (CRT)

- 44 5-point Likert scale questions
  - 28 regarding perception of care
  - 12 regarding life improvement related to services
  - 4 regarding social connectedness
- 3 question regarding arrest history
- Room for comments

Survey Construction (Parent)

- 32 5-point Likert scale questions
  - 25 regarding perception of care
  - 7 regarding life improvement related to services
- 1 question regarding community life
- 3 open ended questions regarding the helpfulness of services
- Room for comments

Survey Construction (Children)

- 31 5-point Likert scale questions
  - 25 regarding perception of care
  - 6 regarding life improvement related to services
- 1 question regarding school attendance
- 3 open ended questions regarding the helpfulness of services
- Room for comments

Survey Methodology

Specific Population Focus

- Adults with serious mental illness who receive CRT services
- CRT consumers who received Medicaid-reimbursed services from CRT programs during January through June
- Children and Parents of children ages 14-18 who received children and adolescent mental health services
- Children and Parents of children who received Medicaid-reimbursed services during September through December

Sample Selection Process

- 75% random stratified sample (CRT and Parents)
- The Children's survey is sent to all children ages 14-18 who receive 6 or more Medicaid-reimbursed children and adolescent mental health services

Data Collection Methodology

- Letter and Surveys are mailed to the sample population
- Questionnaires are not anonymous but are treated as personal/confidential information
- After approximately 2 months, a second letter and survey are sent to those who have not responded

Survey Methodology

Historical Response Rates

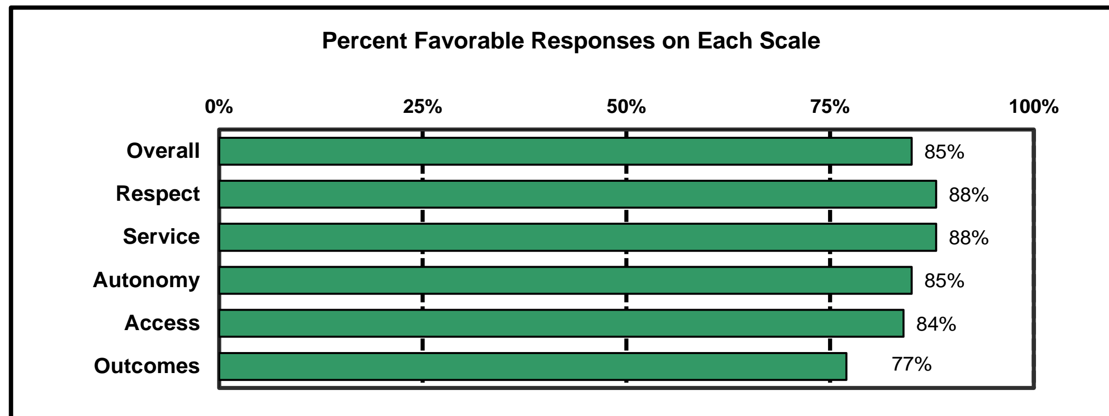
- Response rates from previous CRT surveys had declined from 53% in 1997, to 50% in 2000, 45% in 2003, 36% in 2006, and 19% in 2007, before rising to 40% in 2008, 39% in 2010, 36% in 2011, 22% in 2012, and 31% in 2013

- Response rates from previous Parent surveys had declined from 28% in 2002, to 24% in 2006, 22% in 2008, 21% in 2010, and 23% in 2012

- Response rates from previous Children's surveys had declined from 28% in 1999, to 21% in 2003, 14% in 2007, 18% in 2009, 20% in 2011, and 18% in 2013

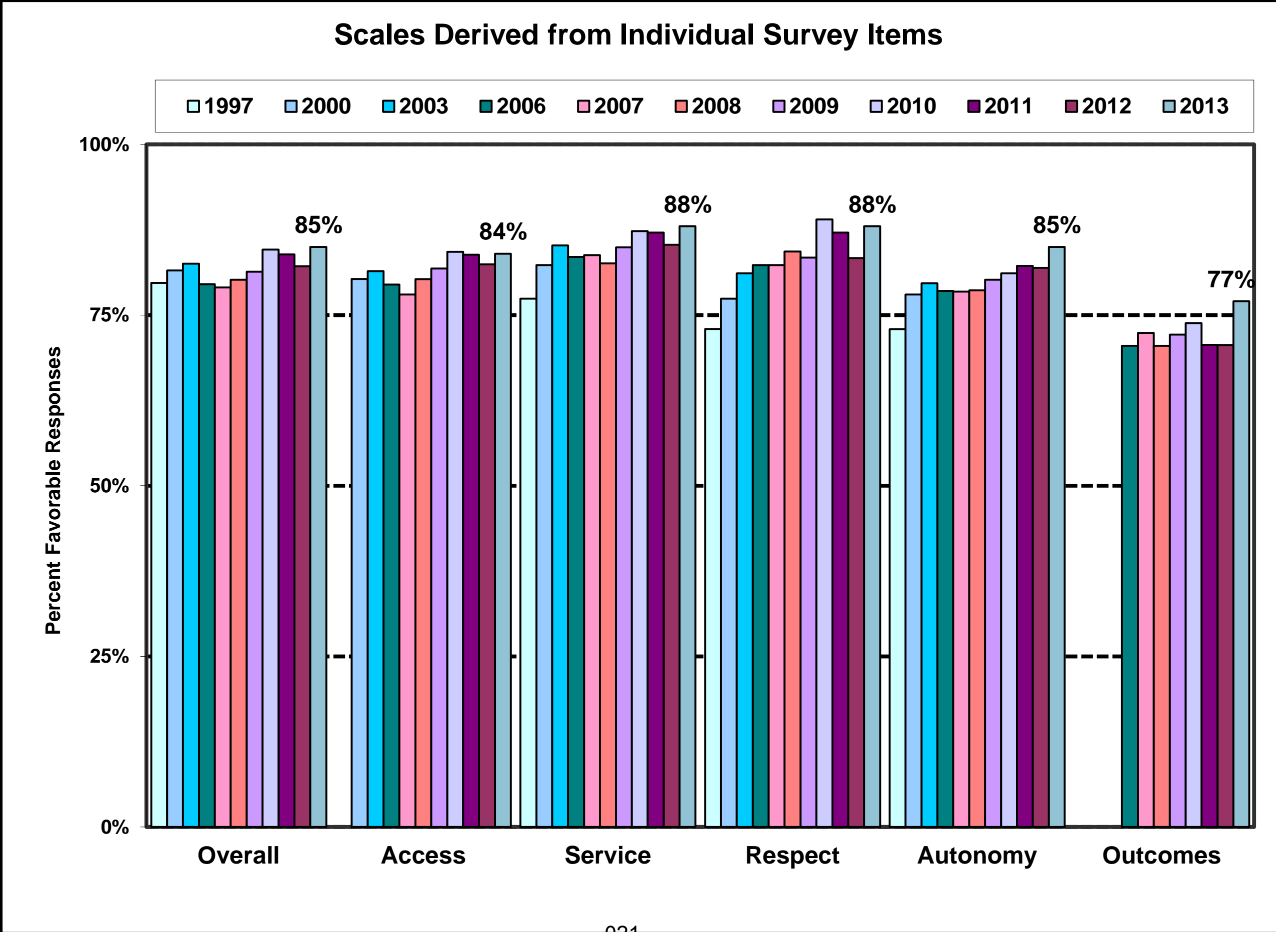
Key Findings

CRT Survey – Most Recent Year (2013)



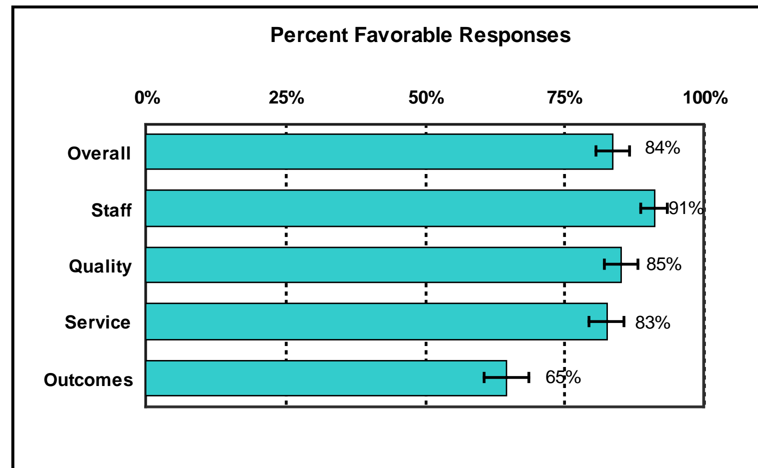
Key Findings

CRT Survey – Trends Over Time



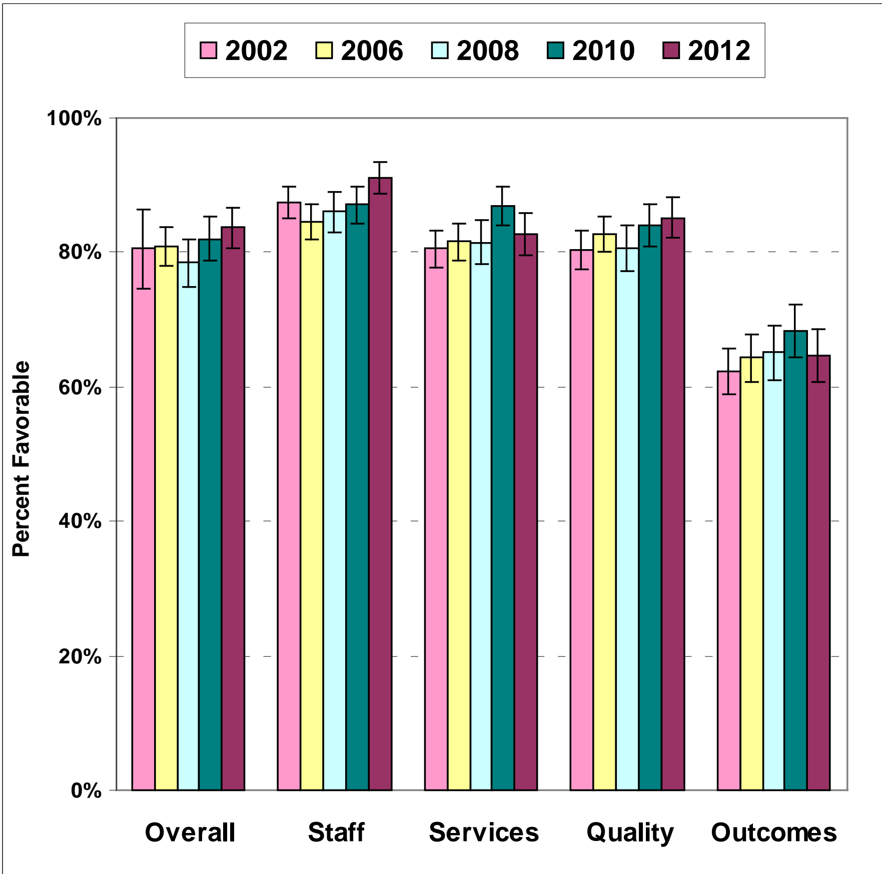
Key Findings

Parent Survey– Most Recent Year (2012)



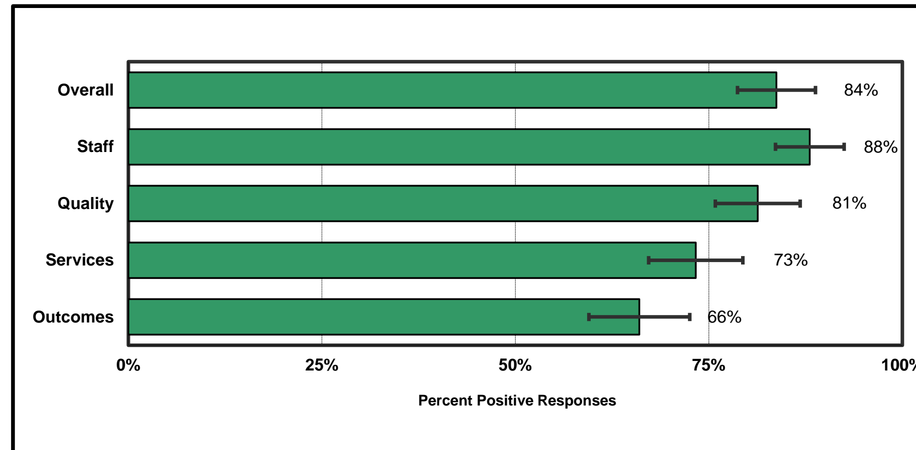
Key Findings

Parent Survey – Trends Over Time



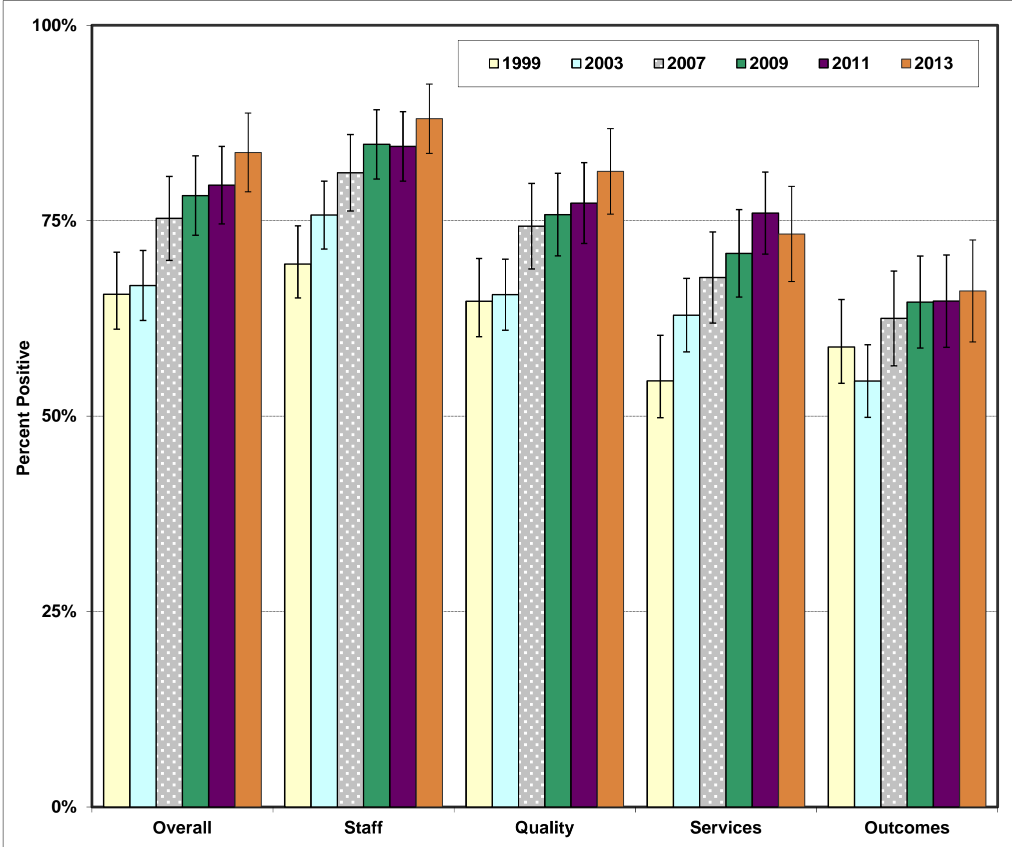
Key Findings

Children's Survey – Most Recent Year (2013)



Key Findings

Children's Survey – Trends Over Time



Questions?

Attachment 3a - Frail Elders Proposal January 2015

Frail Elders Project

Purpose, Deliverables and Budget
February 1, 2014-June 30, 2014

Core Community Practices Leadership Community

The Frail Elders Project is a clinician led quality improvement initiative designed to increase the value of the health care system – focusing on things that matter to patients, reducing harm, conserving resources and increasing system efficiencies. Redesigning how high risk rural elders are cared for offers opportunity to improve health outcomes for a particularly high need population while decreasing the cost of care for the target population.

Method: This section includes how this project will be performed**.**

This project will begin with a literature review. Once the literature review is complete, the project team will design two questionnaires. One questionnaire will be targeting those who are engaged in delivering care to rural elders in Vermont and one will target rural elders. The project team will develop these proposed questionnaires and solicit feedback from a project Expert Panel. The project's Expert Panel will include, but not be limited to, representatives from the following: AAAs, SASH, AHS departments (including the Blueprint for Health), VNAs, Nursing Homes, FQHCs, primary care providers, specialists (including a geriatrician), the LTC Ombudsman, and others currently engaged in delivering care to rural elders in Vermont.

Once the questionnaires are designed, the project team will identify interviewees. This will be done in consultation with the Expert Panel identified above.

The project team will interview those caring for rural Vermonters first and then perform the patient and family survey. The first set of interviewers will include those who determine eligibility for Vermonters.

Deliverables: This project will develop recommendations for the VHCIP Payment Models Work Group in the following areas:

<u>Billing, Claims and Clinical data inquiry:</u>

1. Who are the frail elderly? Can we ID through claims and clinical data?
    a. Identification of target population using both billing and clinical datasets
    b. Existing Vermont and national research
2. Who cares for the frail elderly? This will be answered through the literature review and identification of how we can capture transitions work.
    a. Attribution of patients to care providers- what attribution options are possible?
    b. Existing Vermont and national research

<u>Patient and Family Survey: (Note, these questions are illustrative)</u>

1. What things matter to the frail elderly and their families?
    a. Patient and family survey of target service area population

b. Existing Vermont research
c. Literature review

Provider interviews: (Note, these questions are illustrative)

1. What things matter to the frail elderly and their families?
2. What works well and what doesn't?
3. What practice redesigns could improve care?
4. What are the financial and regulatory barriers to giving needed care?
5. What are practical, meaningful measures of value?

The project team will deliver a written report and a formal presentation to the VHCIP Payment Models Work Group on findings and recommendations for next steps to increase the value of health care to frail elders.

The claims and clinical data analyses will be performed by in state experts, including Steve Kappel from Policy Integrity.

Approximately, xx patients/families will be interview in each of two primary care service areas.[1]

Approximately 20 providers, this list will be identified in conjunction with the Expert Panel, will be interviewed in each of two primary care service areas, Gifford Health Care and Little Rivers Health Care, spanning all or parts of Orange, Washington, Caledonia and Windsor counties. The list of providers will be informed by the key informant interviews described above.

[1] Primary Care Services Areas as defined by the Department of Health.

Attachment 3b - DLTSS Work Group Letter to the Governor

109 State Street

Montpelier, VT 05609

www.healthcareinnovation.vermont.gov

To: Mark Larson and Al Gobeille, Co-Chairs VHCIP Steering Committee
Fr: Georgia Maheras, Project Director, VHCIP
Date: January 15, 2015
Re: Letter from the DLTSS Work Group

This memo is to provide background on a letter to the Governor that the DLTSS Work Group is recommending be sent.

On December 4, 2014, the DLTSS Work Group approved a letter related to Medicaid funding. This letter, attached herein, requests for appropriate levels of Medicaid funding as well as development of alternative payment methods for long term services and supports providers. This letter was approved on a 9-4 vote, with one abstention by the work group with all state employees either recusing themselves or opposing the letter. In addition to this letter, a separate, but similar letter was sent to the Governor in December from Vermont Legal Aid with several co-signers.

DRAFT LETTER FROM DLTSS WORK GROUP

DATE

The Honorable Peter Shumlin
109 State Street
Montpelier VT

Dear Governor Shumlin,

Several members of the Disability and Long Term Services and Support (DLTSS) Work Group of the Vermont Health Care Innovation Project (VHCIP), those who do not work for state government, would like to share our perspective on how the services that our group represents are of critical importance to both health care reform and the State's current and future fiscal status. The population that receives DLTSS is responsible for 72% of Medicaid claims, utilizing both acute and long term care services.

Given the State's fiscal projections, we want to ensure that the State is strategically utilizing health care resources for the best return on investment in order to achieve our shared goals of health care reform: better outcomes, better health care experience and reduced costs. We are particularly concerned about any proposed reductions to services for Medicaid recipients who utilize long term services and supports (developmental, mental health, elderly and disabled home-based health care). In order to achieve savings, health care reform depends on staff in these programs to manage and coordinate health care, with the stated goal that managing health care will reduce costs, by reducing the cycle in and out of more expensive settings. We therefore make the following recommendations:

1. Medicaid rates should be high enough to recruit and retain quality staff across the full continuum of health care providers to provide access to quality care. At this point, there is insufficient room left in commercial insurance rates to continue the shifting of costs from public programs to the private payers. Providers who rely solely or significantly on Medicaid for their funding are in even greater need for improved Medicaid rates as they are not able to cost shift.
2. Further, it is essential that reimbursement rates from our public programs increase on a predictable and reliable basis in order to sustain quality services.
3. The State should not delay in working with willing community-based providers to develop bundled payment models that reimburse for specific population outcomes. The current fee-for-service payment model from siloed funding streams, which come with multiple bureaucratic requirements, wastes state resources and doesn't have the flexibility to best meet the needs of Vermonters. The experience to date with Integrated Family Services (IFS), a bundled payment pilot in two areas of the State, has shown improved services, reduced administrative expenses and savings.

4. The VHCIP should move forward in developing payment models for DLTSS services which will complement the Medicaid Accountable Care Organization (ACO) Shared Savings Program, with a commitment to achieve comprehensive services and supports for individuals who have been attributed to an ACO as well as for those who have not. Many of these individuals need access to care management to achieve better health outcomes.

While we are fully cognizant of revenue shortfalls for fiscal years 2015 and 2016, we are certain that any reductions in Medicaid funding for services to individuals with DLTSS needs will only lead to higher health care costs for the entire system, most likely through increases in inpatient and institutional care. Many of the state's health care providers are already stressed and cannot further reduce expenditures without also reducing services to people with DLTSS needs. Further reductions in funding will cause detrimental impacts on vulnerable Vermonters.

There is consensus from a diverse cross-section of consumers, advocates, providers and other stakeholders on these recommendations. More importantly, we have commitment, determination and innovative ideas to move health care reform forward.

Sincerely,

The non-governmental members of the DLTSS Work Group

Cc: Secretary Chen
Secretary Spaulding
Chairman Gobeille