LUGPA
Integrated Practices Comprehensive Care

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Chairman Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

Ranking Member Mike Crapo
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Dear Chairman Wyden and Ranking Member Crapo,

Thank you for offering the Large Urology Group Practice Association (LUGPA) the opportunity to comment on your white paper "Bolstering Chronic Care Through Physician Payment: Current Challenges in Medicare Part B." LUGPA represents 150 urology group practices in the United States with more than 2,100 physicians who, collectively, provide more than one-third of the nation's urology services.

The recent release of the C.Y. 2025 Physician Fee Schedule continues the alarming trend of cuts to reimbursement for physician services, which are magnified by inflationary pressures. The 2025 proposed rule would implement a 2.8% reduction and illustrate how broken the payment system currently is for the clinical practice of medicine. If Congress does not act before the end of the year, Medicare payments will have been cut by more than 7 percent over the past four years while practice costs continue to skyrocket.

Just as concerning, Medicare continues its perpetual policy of generous payment updates to large hospital systems, thereby exacerbating the extraordinary imbalance in their favor as more and more independent practices struggle to hold on to their physicians, nurses, and back-office staff to perform many of the identical health care services for patients, are forced to shut their doors, retire early or become employed. This system is unsustainable for our nation's medical groups, physicians, and other healthcare providers. The effects of these cuts will be more severe in rural and underserved areas, which can and will continue to face significant healthcare access and resource challenges.
These cuts fundamentally recapitulate the failed Sustainable Growth Rate (SGR) formula that repeatedly brought providers to a fiscal cliff that we thought Congress had disposed of almost a decade ago. However, repeated cuts are back and appear here to stay unless Congress undertakes fundamental reform. The net effect is devastating to physician practices, already crippled by years of marked inflation and staffing and supply chain challenges. Moreover, independent practices have been all but shut out of alternative payment models (APMs), with little demonstration of interest from CMS in either developing specialty-care value care arrangements or in implementing recommendations from the physician community. More must be done to stabilize physician payments and allow practices to transition to value-based care paradigms to better care for their chronic care patients.

LUGPA would like to offer several recommendations of action that Congress should take to bolster the health care system, particularly for chronic care patients:

I. **Reform payment updates by:**
- Eliminating the pending cuts to the Medicare Physician Fee Schedule (MPFS and
- Replacing the current system with a methodology reflecting actual costs of care (e.g., at least the MEI) so we have reliable and predictable payment updates.

II. **Promote the adoption of Physician-Focused Payment Models (PFPMs) by:**
- Reforming the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to afford independent physicians' meaningful input into APM development and review;
- Require CMS to pilot-test PTAC-approved APMs; and
- Encourage CMMI to evaluate and adopt PFPMs independent of the PTAC process.

III. **Repeal the zero-sum game in MIPS and work towards replacing it with one that meaningfully rewards quality and value** and does not fund bonuses to physicians through penalties to others. In the interim:
- Congress should eliminate the winner/loser system in the MIPS program and reward higher-performing practices.
- Reauthorize and expand the $500 million bonus pool for exceptional performers.

IV. **Move Medicare towards site-neutral payments for physician-administered drugs and outpatient surgical procedures and use these savings to help finance physician payment reform**. This can be done by modestly decreasing hospital payments and modestly increasing physician practice payments, even though total neutrality need not be achieved.

V. **Codify the administrative reforms made to the Stark and Anti-Kickback laws and build on those reforms to encourage physician practices to develop innovative, integrated, value-based models of care**. Ultimately, these models should evolve into risk-sharing arrangements that align payments with outcomes and expenditures.

I. Congress Must Act to Stop Statutory Payment Cuts and Payment Redistribution

In its proposed C.Y. 2024 MPFS rule, CMS cuts the conversion factor by 2.8% to $32.36 as compared to $33.29 in C.Y. 2024.[1] LUGPA is deeply concerned that the pending substantive payment cut will have a long-lasting impact on physician practices, which are still recovering from the COVID-19 pandemic and facing severe inflationary pressures. The temporary patches

[1] Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments. [CMS-1807-P]

made in the last several years were part of a national effort to support providers reeling from the pandemic's impact on the healthcare system, including mandatory shutdowns to some of providers' most profitable elective services, supply shortages, necessary and costly care delivery transformations to telehealth for providers, and an abrupt refocus on care delivery for COVID-19 patients.

Even if this cut is averted, physician payment updates have been totally inadequate, failing to keep up with even the most conservative estimates of inflation. Physician practices continue to feel the effects of nationwide labor shortages. When adjusted for productivity, staffing levels continue to decline, with Support Staff FTEs per 10,000 work RVUs down 6 percent from Q4 2022 to Q4 2023, as open positions are going unfulfilled. Compared to actual data, the lack of payment adjustment seems wholly inadequate. Physicians need a predictable payment update akin to the market basket – the Medicare Economic Index (MEI). Temporary patches and imperceptible updates and freezes must be replaced with dependable annual payment increases that reflect practice costs, which are provided to every other facility provider in Medicare.

Every year, Congress must take action to avert these cuts temporarily, but given that these are the result of statutory changes, we now seem to be returning to the SGR era—physician practices are again being diverted from patient care and being consumed by anxiety as to whether they will shortly be able to afford to keep their doors open.

II. Improving Urological Chronic Care Through Pilot-Testing APMs

MACRA's promise to help physicians move to value-based care has not been realized. While many large hospital systems have enrolled in accountable care organizations (ACOs) and leveraged that participation to acquire physician practices, independent physician practices have largely been left behind. Only 17 percent of participating providers (roughly 227,0000 clinicians) received an APM Incentive Payment in 2023.[2]

Urologic physician practices routinely manage a number of chronic conditions, such as Benign Prostatic Hyperplasia (BPH) (where the prostate is enlarged but not cancerous), prostate cancer, incontinence, recurrent urinary tract infection (UTI), and kidney stones. CMS's guidance regarding proper G2211 utilization for 'longitudinal' care supports the assessment that the significant majority of genitourinary (G.U.) office visits qualify as "…medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition."[3]

Urology providers are one of the most frequent points of healthcare contact for many older male patients whose prostate condition represents their most severe or significant ongoing healthcare issue. This extends to patients with both benign and malignant prostate conditions. Monitoring and treatment of prostate cancer may involve years, if not decades, of care and involves

[2] Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B. Senate Committee on Finance. May 17, 2024

[3] Centers for Medicare and Medicaid Services. "CMS Manual System: Guidance for the Implementation of the Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Code G2211." January 18, 2024

sequential interventions over time. Furthermore, oncology treatment and care improvements have significantly increased the quality of life and lengthened the life years of patients. Still, treatment regimens can be complex and require a partnership between the patient and their urology practice to ensure proper coordination, follow-up, and monitoring, management, and mitigation of side effects. In these advanced prostate cancer patients, coordination between the patient and the office often occurs at least once a month in a long-term fashion and may occur many times weekly during acute issues or changes in treatment.

The principal care model (PCM) and Chronic Care Management (CCM) programs are integral to educating the patient and engaging in their care. It is challenging to keep many patients adherent to their medications. For example, BPH men are on medications for an extended period where there are documented side effects that have a cost to the health ecosystem. Helping these men come off medications for other therapies happens when providers can keep these patients engaged in their care or the medication(s) does not work. LUGPA views PCM/CCM as a critical part of transitioning these patients to other therapies that may reduce their medication utilization as well as mitigate long-term complications.

Similarly, chronic urinary tract infections (UTIs) impact these patients disproportionately. In patients with nosocomial UTI treated in urology, the prevalence of urosepsis was, on average, about 12% in a multinational surveillance study. Severe sepsis is a critical situation with a reported mortality rate ranging from 20% to 50%[4], which has an impact on the practice both in the delivery of care, the engagement of patients in their care, and stretching increasingly limited practice resources. And, even in those patients who fully recover from a septic episode, there are often longstanding health complications as a result. Furthermore, these episodes consume vast resources, with costs per event ranging from $18,023 to $51,022 in cases complicated by multi-system organ failure[5].

These serious chronic conditions are ripe for various APMs that the physician community could develop to improve patient care and reduce overall healthcare spending. For example, an APM for the management of benign (enlarged) prostate disease could measure complications such as E.R. visits for acute urinary retention (AUR) renal failure specifically because of urinary tract infections. Physicians could take the risk of managing these conditions and share in the savings with the Medicare program if costs are reduced and outcomes are improved. Another APM could focus on advanced prostate cancer that looked at compliance with therapy, QOL measures, and bone density. A third idea could focus on a reduction in the incidence of urosepsis.

Regrettably, none of these ideas to improve the management of urological chronic care can proceed because the vision Congress pursued in MACRA of inviting the physician community to develop their own ideas about innovative APM delivery programs and "let a thousand flowers bloom" has not come into fruition. Indeed, while 17 PFPMs were recommended for approval or

[4] Wagenlehner FME. Pilatz A. Weidner W. Naber KG. 2015.Urosepsis: Overview of the Diagnostic and Treatment Challenges. Microbiol Spectr 3:10.1128/microbiolspec.uti-0003-2012.https://doi.org/10.1128/microbiolspec.uti-0003-2012

[5] Paoli CJ, Reynolds MA, Sinha M, Gitlin M, Crouser E. Epidemiology and Costs of Sepsis in the United States-An Analysis Based on Timing of Diagnosis and Severity Level. Crit Care Med. 2018 Dec;46(12):1889-1897. doi: 10.1097/CCM.0000000000003342. PMID: 30048332; PMCID: PMC6250243.

pilot testing, CMS failed to implement or test any of these. [6] Physician organizations have no incentive to pursue other ideas if NONE of their PTAC-approved APMs are being implemented, even on a pilot basis.

Rather than develop PFPMs, CMMI is clearly focused on broader, system-wide reforms that are time-consuming to develop, cumbersome to launch, and resource-intensive to implement. In contrast, models developed by providers "in the trenches" who clearly understand where payment policy may be misaligned with quality and cost concerns—it is in the fostering of innovation by those rendering care where opportunity truly lies.

In short, CMS should be required to pilot-test PTAC-approved APMs in a discrete geographic area (e.g., no fewer than three MSAs and one rural area), three-year duration, and diverse demographic patient population. They can then be evaluated for quality and patient outcomes improvements and savings on whether they should be expanded, modified, or terminated. Congress should pivot to broader-scale evaluation and testing of numerous models that can be rapidly undertaken, implemented, and evaluated for cost containment and quality improvements—allowing for the refinement and expansion of promising and successful models.

III. MIPS Does Not Promote Value-Based Care

The Medicare Incentive Payment System (MIPS) has been an even bigger disappointment and only served to burden physicians with onerous, expensive, and essentially meaningless reporting requirements. A 2021 study published in JAMA Health Forum found that it costs an estimated $12,811 and takes more than 200 hours per physician to comply with MIPS.[7] And even with that investment of resources, there are serious questions about whether these investments result in any meaningful upside for practices— especially for smaller, independent practices where the administrative burden and up-front financing are particularly challenging—and whether the MACRA program actually results in higher quality care. MIPS participants can theoretically receive payment bonuses up to 7% or penalties up to 9% based on their performance score within the four categories of the program: quality, cost, promoting interoperability, and improvement activities.

However, since the program is designed to be budget neutral, these positive adjustments can only increase and improve if other practices do not increase their own MIPS scores and are penalized for poor performance. The design of MIPS discourages collaborative care and efforts to enhance the quality across the system, as high-performing practices will be reluctant to share best practices and risk receiving smaller, positive payment adjustments as other practices improve their scores. Moreover, because many of the MIPS metrics were so meaningless that almost all practices that reported data were not penalized, the upside potential of being a high-achieving practice was negligible. This is evident in a 2021 Government Accountability Office (GAO) report that found only 0.29% of participants received a negative adjustment.[8]

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[6] Physician Focused Payment Model Technical Advisory Committee. PTAC Proposals and Materials, available at: https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposalsmaterials#1061

[7] Shullar, Dhruv et. al.,Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System. JAMA Health Forum. May 14, 2021

[8] Medicare Provider Performance and Experiences under the Merit-based Incentive Payment System. Government

LUGPA's own Dr. Tim Richardson of Wichita Urology testified at the Ways and Means Committee that "our nursing manager, I.T. manager, and Director of Operations spend hours each week and days at the end of each year making sure the data is reported appropriately. We estimated that, at a minimum, this adds 3 minutes per patient encounter, which may not sound like a lot but averages 10-20% of the time of a typical patient visit. With over 13,000 Medicare patient encounters per year in my practice, this equates to over 12 additional hours per week that could be used for patient care instead of paperwork. Unfortunately, all the resources spent to collect and disseminate MIPS data are not useful in promoting higher quality care by physicians nor helpful in informing patients which doctors deliver higher quality care than their peers. Furthermore, as currently designed, MIPS offers no realistic way for practices to recoup the cost and burden of participating given the budget-neutral status of the program."

The Medicare Payment Advisory Commission (MedPAC) commented, "MIPS as presently designed is unlikely to succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value, or helping the Medicare program reward clinicians based on value." [9] When the experts advising Congress state the program has been a failure and the facts are equally damning, it is time for Congress to terminate MIPS.

It is clear that the MIPS program has failed to deliver on its promise to improve quality and reward higher-functioning providers. LUGPA supports the repeal of MIPS but does not support replacing it with another untested system that relies on punishing physicians via economic measures or publishing statistics based on adherence to largely meaningless metrics. LUGPA strongly recommends that Congress adopt two simultaneous paths:

- Encourage healthy competition in the market by leveling payment disparities between sites of service and encourage the development of value-based payment models through statutory modification of Stark and Anti-Kickback statutes (discussed later in this document); and

- Act to immediately stabilize the MIPS by reauthorizing and expanding the $500 million exceptional performance bonus and eliminating the zero-sum provisions of the program.

IV. Payment Differentials Between Sites of Care

Independent physician practices provide high-quality, accessible care in the community yet are forced to compete with hospitals under payment models that heavily favor these larger, more expensive sites of care. Site-of-service payment differentials were developed at a time when complex care was delivered almost uniformly in a hospital setting. These payment discrepancies for identical services are an anachronism considering the tremendous technological and clinical innovations advancing the scope of care available in outpatient settings. Now, it serves to divert care to more expensive (and often riskier) inpatient and hospital settings. Further, the policy of paying hospitals substantially more (often more than twice as much) for the identical services

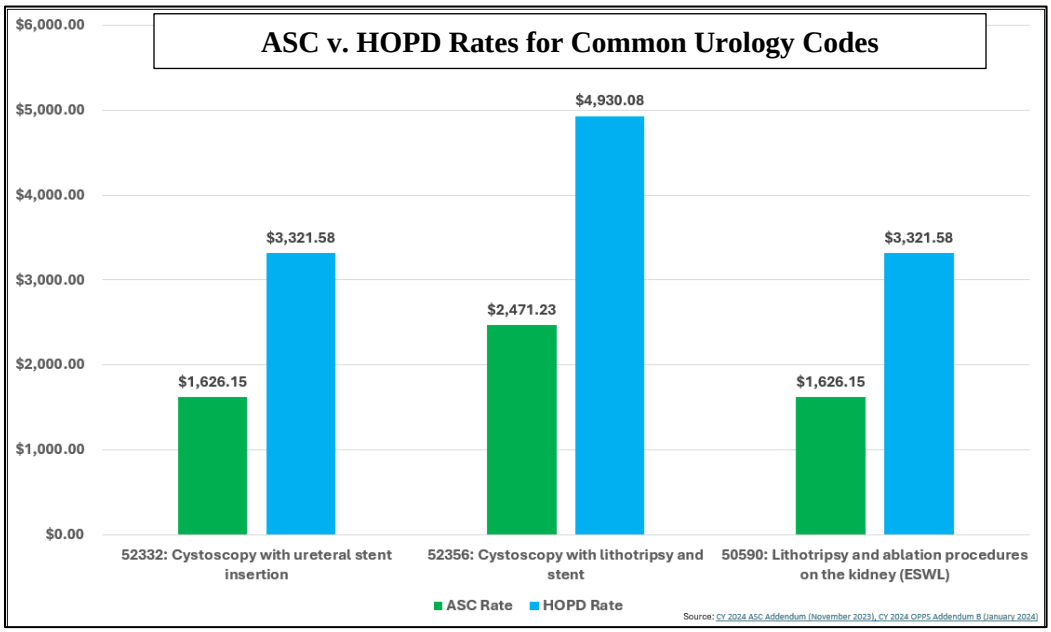
Accountability Office. October, 2021.

[9] Redesigning the Merit-based Incentive Payment System and Strengthening Advanced Alternative Payment Models. Report to the Congress. Medicare Payment Advisory Commission. June 2017.

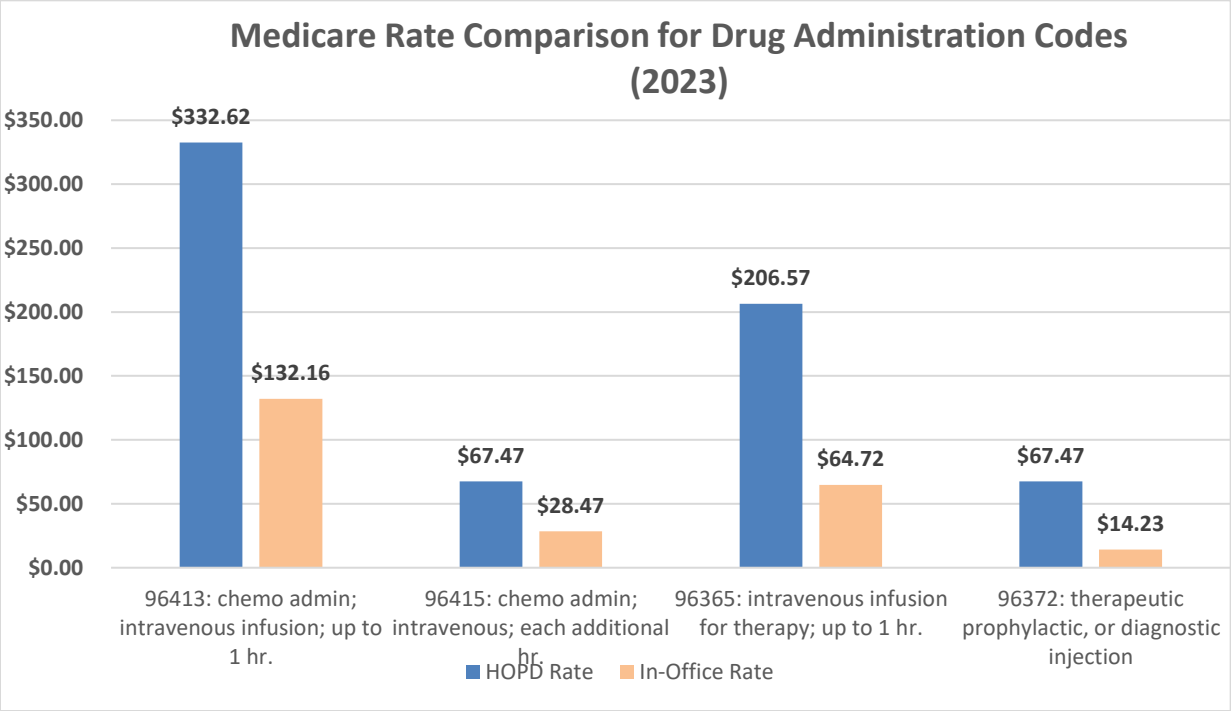
provided in a physician's office or ambulatory surgery center (ASC) paradoxically acts as a disincentive to pursuing innovations that could shift care out of the higher cost hospital setting, thereby perpetuating inflationary cost trends and inhibiting patient access. These payment differentials waste taxpayer and beneficiary dollars and provide mega-hospital systems with additional resources and incentives to acquire physician practices, promote consolidation, limit competition, and restrict patient treatment options.

In 2015's Balanced Budget Act, Congress endorsed the principle of preference for care delivery in the lowest cost equivalent site of service. Implementation of these site-neutral recommendations has the potential for massive savings, both to taxpayers and directly to beneficiaries in premiums and copays. A Committee for a Responsible Budget study demonstrated $153 billion of net savings to the Medicare program over a decade if site-of-service payment differentials were eliminated. Medicare beneficiaries would save an additional $137 billion, including $51 billion in lower premiums and $43 billion in lower cost-sharing, plus an additional savings of $43 billion for those with Medigap coverage.[10] Medicare's overall spending on affected services would fall by roughly half once the policy is fully implemented.

For example, Medicare pays hospitals more than twice the amount as physician offices for a cystoscopy with lithotripsy stent (CPT code 52356), even though this requires the same staff, infrastructure, time, and technical training. Hospitals are paid $4,390, while physician-owned ambulatory surgery centers are paid $2,471.23 for an identical procedure.



[10] Committee for Responsible Budget "Equalizing Payments Regardless of Site of Care" February 2021., MedPAC, "Report to Congress: Medicare Payment Policy," March 2019, Chapter 4. In 2018 HOPDs were paid $166 for the most common E&M visit for established patients compared with $74 for the same visit provided in a physician's office. MedPAC and CMS use E&M or "clinic visit" at different times to describe similar interactions so in this brief we use both terms, MedPAC, "Report to Congress: Medicare Payment Policy," March 2019, Chapter 5. e



Similarly, Medicare pays more than twice as much to hospitals to infuse the same drugs that require the same nurse staff time and technical training compared to what Medicare pays in a physician's office ($325.64 in the HOPD setting vs. $140.16 in the physician's office).[11] [12] Even more concerning is that the patients are penalized for receiving their physician-administered Part B drug in the physician's office because the law caps Medicare beneficiaries' out-of-pocket liability in the HOPD setting at $1,600, yet Medicare beneficiaries who receive their infused drugs in their own doctor's medical office face unlimited liability based on 20% of the total cost. (The IRA capped beneficiary liability for Part D drugs but did not enact a similar cap for Part B drugs, which are typically much more expensive.)

These changes are not theoretical. Data suggests that there has been a marked shift away from the physician's office toward the HOPD for the administration of outpatient chemotherapy.[13] In addition to the above trends, it has been demonstrated that the acquisition of physician practices by hospitals is an additional important driver of this change[14], particularly since 340B hospitals can also then benefit from the vast profit margin on the administration of certain medications to the newly incorporated patient population of the acquired practice.

[11] CY 2024 ASC Addendum (November 2023)
[12] CY 2024 OPPS Addendum B (January 2024)
[13] Winn AN, Keating NL, Trogdon JG, et. al. Spending by Commercial Insurers on Chemotherapy Based on Site of Care, 2004-2014. JAMA Oncol. 2018;4(4):580–581.
[14] Jung J, Feldman R, Kalidindi Y. The impact of integration on outpatient chemotherapy use and spending in Medicare. Health Econ. 2019 Apr;28(4):517-528.

A provision in the "Lower Costs, More Transparency" bill (H.R. 5378), which passed the House last year, addresses this issue with respect to off-campus hospital outpatient departments by requiring parity for Part B drug administration. That provision and the one requiring a separate identification number and an attestation for each HOPD department saved Medicare $4.1 billion over ten years.[15] Congress could build on that policy by applying site neutrality to drug infusions provided on hospitals' campuses, where most occur. For example, savings would increase 10-fold if CBO determines that only about 10% of HOPD drug administration occurs on "off-campus" sites.

We underscore that payments need not be entirely equalized by simply reducing hospital payments. Congress should consider closing payment disparities by modestly reducing hospital payments while modestly increasing payments to physicians for the same services to ensure patient access is protected. We do not support the MedPAC recommendation that would cut ASC payments to the physician office rate if just a plurality of volume is provided in the physician office setting. Rather, we recommend retaining CMS's majority rule of physician office volume to trigger lower ASC payments, as is currently the case. The real opportunity for savings is the higher cost procedures that could migrate from HOPD to ASC, where no current site-neutrality payment structure applies. Excessive payment cuts to the ASC setting could result in many of those procedures reverting to the HOPD setting rather than diverting them to the physician's office.

V. Statutorily Reforming the Stark Law and Anti-Kickback Laws

It has been shown that competition in the healthcare market improves outcomes and reduces costs.[16] Regrettably, physicians are barred from owning hospitals and are subject to antiquated laws enacted 35 years ago. The Affordable Care Act permanently barred new physician-owned hospitals and barred growth of current physician-owned.

Dr. Brian Miller noted that because of the ACA's statutory ban, "more than $275 million of planned economic activity spread across 45 hospital expansion projects ceased. More than 75 new hospitals, either planned or under development, were prematurely terminated, representing more than $2.2 billion in economic losses. Intangible losses include the loss of the "physician entrepreneur" and user-driven innovation in the face of increasing corporatization of medical practice, both likely contributing to the increase in physician professional dissatisfaction… Premature foreclosure of the POH marketplace inhibited the development of the U.S. version of the "focused factory" model of specialized hospitals or integrated Reversing Hospital Consolidation: model of specialized hospitals or integrated practice units, a feature seen in other markets." [17]

[15] Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act. Congressional Budget Office. December 8, 2023

[16] Gaynor M, Moreno-Serra R, Propper C. Death by market power: reform, competition, and patient outcomes in the National Health Service. American Economic Journal: Economic Policy. 2013 Nov 1;5(4):134-66.

[17] Brian Miller et al. “Reversing Hospital Consolidation: the Promise of Physician-Owned Hospitals” Health Affairs

LUGPA worked closely with aligned stakeholders to encourage updating existing regulations governing the Stark statute and strongly supports the administrative reforms made by both CMS and the HHS Office of the Inspector General (OIG) in December 2020. The OIG administrative changes created three new safe harbors to encourage value-based care models: (1) care coordination arrangements without requiring the parties to assume risk; (2) value-based arrangements with substantial downside financial risk; and (3) value-based arrangements with full financial risk. Simultaneously, CMS adopted revisions to the Medicare self-referral statute, which was also designed to support value-based payment arrangements in the Medicare program.

Although these regulatory changes helped advance the adoption of payment arrangements that reward value over volume, they remain constrained by the underlying statutes. Furthermore, these regulations are complex and challenging for providers to understand. As a result, practitioners have been reluctant to enter new or innovative payment arrangements for fear of triggering unintentional violations of the underlying statutes or investigations by overzealous prosecutors. In addition, the adoption of these programs is hampered by logistical challenges for practices remain as compliance is carried out while dealing with real-time patient pressures and practice resource constraints.

LUGPA strongly supports the development of alternative payment models and value-based payment arrangements and believes there is a clear need to amend these underlying statutes to better facilitate the adoption of payment arrangements between physician specialists, primary care physicians, and facilities. Ultimately, these changes should encompass stakeholders such as pharmaceutical, biotechnology, medical device manufacturers, and other vendors. Specifically, we propose an amendment to each of the Social Security Act §§ 1128A and B; 1877 and 1927 that would expressly carve out protection for payment arrangements designed to promote value-based care.

As these changes are contemplated, LUGPA recognizes and supports the need for appropriate program protections to ensure proper economic oversight and patient protections. Miller et al. presented an excellent framework advocating for expanding self-referral exceptions when being used within capitated, risk-adjusted payment programs, which would include Medicare Advantage and Medicaid managed care.[18] Self-referrals could also be tied to an easily identifiable measure, such as payer status, allowing for more streamlined use of the exceptions, saving practices time and much-needed resources. These changes would support independent practices by increasing competition between hospitals and physician-owned models of care while still driving the transition to value-based care.

Conclusion

The pay-for-performance programs established by MACRA are profoundly flawed and do little to drive physicians toward value-based care. Congress must act to protect physicians by providing stable payment updates that reflect the realities of the economy and healthcare practice costs.

[18] Miller BJ, Ehrenfeld JM, Wu AW. Competition or Conflict of Interest—Stark Choices. JAMA Health Forum. 2021;2(2):e210150.

LUGPA stands ready to work with Congress to improve MACRA and recommends that Congress take immediate action to:

1. Block pending cuts and replace MACRA's current payment system with updates based on practice costs – i.e., Medicare Economic Index.

2. Encourage the development of APMs by the physician community – those in the trenches delivering care – by pilot-testing PTAC-approved APMs.

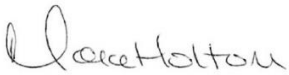
3. Repeal the onerous and ineffective MIPS program and establish more meaningful payment rewards for high-performing practices under MIPS, including removing the zero-sum provisions of the program as well as reauthorizing and expanding the bonus payments for exceptional performance.

4. Ensure that site neutrality payments are realized to prevent patient access issues and the driving up of health care costs through provider consolidation and excessive payments to hospital systems and use those savings to help finance physician payment reform; and

5. Reform the outdated Stark statute—only statutory amendments will provide the certainty to practitioners that they will not be penalized for entering arrangements that may run afoul of technical provisions of the law.

On behalf of LUGPA, we would like to thank you for allowing us to comment on physician payment reform. We are happy to be a resource as different policy options are explored. Please feel free to contact John McManus at jmcmanus@mcmanusgrp.com or Tracy Spicer at tspicer@dcavenuesolutions.com.

Thank you,



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