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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

November 2008 **Report No. 08-64**

Medicaid Reform: Reform Provider Network Requirements Same as Traditional Medicaid; Improvements Needed to Ensure Beneficiaries Have Access to Specialty Providers

at a glance

While access to providers is expected to improve under Medicaid Reform, the Agency for Health Care Administration uses the same contract requirements to assure that both Medicaid Reform and non-Reform managed care plans include an adequate number and array of providers with offices located within reasonable travel distances. For the most part, the agency also monitors provider network adequacy the same way for both Reform and non-Reform plans. To better ensure that Reform provider networks meet beneficiary needs, the agency should develop additional Reform contract requirements as well as improve its oversight of provider networks.

Information available to Reform beneficiaries about providers participating in Reform plans is not always accurate. As a result, some beneficiaries have experienced difficulty selecting a plan that meets their needs and ensures that they can make appointments to see specialty providers. In addition, there is conflicting evidence to support whether access to specialty providers has improved or not in the Reform counties.

Medicaid Reform

The 2005 Legislature authorized the Agency for Health Care Administration (AHCA) to reform Medicaid with the intent of improving health outcomes of Medicaid beneficiaries and achieving budget predictability. [1] AHCA obtained a federal waiver and legislative approval to implement a managed care pilot program and began providing services to Medicaid beneficiaries in Broward and Duval counties in September 2006. AHCA expanded the pilot to Baker, Clay, and Nassau counties in September 2007. [2] AHCA will need legislative approval to expand Medicaid Reform beyond these five counties. [3]

The major premise of Medicaid Reform is to improve health care delivery services by giving managed care health plans flexibility to better meet the specific needs of Medicaid beneficiaries and to promote competition among these plans. Under Medicaid Reform, health plans can develop customized benefits packages for different beneficiary groups. Medicaid Reform is intended to empower beneficiaries by offering them more managed care options and encouraging them to take an active role in their health care.

[1] Chapter 2005-133, *Laws of Florida.*

[2] AHCA received approval to implement an 1115 Research and Demonstration Waiver application from the Centers for Medicare and Medicaid Services (CMS) in October 2005. The Legislature approved implementation of the waiver in December 2005 (Chapter 2005-358, *Laws of Florida).*

[3] Chapter 2005-358, *Laws of Florida,* established a goal of statewide implementation by June 2011 in accordance with waiver requirements but requires AHCA to obtain legislative approval to expand implementation beyond the pilot sites.

Medicaid Reform beneficiaries receive detailed information on their health plan choices and assistance from specially trained choice counselors to help them select a Reform plan that best fits their needs. Beneficiaries can earn monetary credits for participating in certain healthy behaviors that they can use to purchase health-related products.

Participation in Medicaid Reform in the pilot counties is mandatory for certain low-income children and families and aged and disabled beneficiaries. These include families who have incomes at or below 23% of the federal poverty level, children who live in families that earn up to 200% of the federal poverty level (depending on the children's ages), and individuals who are age 65 and older or disabled and receive federal Supplemental Security Income.[4] Other beneficiaries may choose to participate in Medicaid Reform, including children in foster care, individuals with developmental disabilities, and Medicare beneficiaries who are also eligible for Medicaid (dual eligibles).

As required by Chapter 2005-133, *Laws of Florida*, this is one of a series of reports presenting the results of OPPAGA's evaluation of the Medicaid Reform managed care pilot programs. This report addresses three questions regarding provider networks under Medicaid Reform.

- How does AHCA ensure that Medicaid Reform plans establish adequate provider networks to meet the needs of their beneficiaries?
- Is information provided to beneficiaries on Reform provider networks accurate and sufficient to help them select a health plan that meets their needs?
- Has access to specialty providers improved under Medicaid Reform?

Questions and Answers

How does AHCA ensure that Medicaid Reform plans establish adequate provider networks to meet the needs of their beneficiaries?

Medicaid Reform is expected to improve access to care in the pilot counties. To improve access, AHCA must ensure that Reform plans develop adequate provider networks. However, AHCA uses the same contract standards for both Medicaid Reform and non-Reform provider networks. In addition, AHCA generally uses the same procedures to monitor provider network adequacy for both Reform and non-Reform plans. For AHCA to better ensure that Reform provider networks meet beneficiary needs, it should develop additional Reform contract requirements as well as improve its oversight of provider networks.

AHCA uses the same contract requirements for provider networks in both Medicaid Reform and traditional Medicaid managed care plans. Both Reform and non-Reform managed care plans must have at least one full-time equivalent primary care provider per county for each 1,500 plan beneficiaries.[5] In addition, both types of plans must meet established minimum standards for certain facilities and services such as one birthing center per plan and one licensed pharmacy per 2,500 beneficiaries. Both Reform and non-Reform managed care plans must assure their networks include an array of specialists or that specialists will be available, at a minimum, on a referral basis to meet the needs of their beneficiaries. AHCA also requires that travel times from beneficiaries' homes to provider offices must be reasonable for both types of plans and that beneficiaries are able to see providers within reasonable timeframes to assure they receive the treatment they need. (See Appendix A for detailed information on these requirements.)

[4] In 2008, 23% of the federal poverty level is $4,048 per year for a family of three; 100% of the federal poverty level is $17,600 for a family of three; and 200% of the federal poverty level for a family of three is $35,200.

[5] For each participating full-time equivalent primary care advanced registered nurse practitioner or physician assistant, health plans may increase this ratio to 2,250 beneficiaries for each full-time primary care provider.

AHCA monitors and assesses Reform plans' provider network adequacy and access in the same way it does traditional Medicaid managed care plans, with one exception. For example, AHCA conducts annual site visits to the offices of all Medicaid managed care plans. During these annual visits, AHCA staff check to ensure that plans maintain updated information about their provider networks, including signed contracts from any newly engaged providers. Staff also check to determine whether plans have updated their maps of provider locations and data related to patient to primary care provider ratios. [6]

In addition, AHCA staff review both Reform and non-Reform managed care plans' quarterly grievance reports and results of fair hearings pursued by beneficiaries who have experienced problems related to aspects of their health care, including access to needed care and providers. [7, 8] However, these sources are limited and may not reflect the extent to which beneficiaries have experienced problems with accessing needed care. Grievance reports provide aggregate information about the total number of appeals and grievances that a plan receives; the reports do not identify the number of complaints specifically related to problems with accessing primary or specialty health care. [9] Beneficiaries experiencing problems also may pursue the fair hearing process. However, this process can be difficult and burdensome, as it requires beneficiaries to fill out detailed forms, submit supporting documentation such as medical bills and/or medical records, and represent themselves in hearings unless they have attorneys to represent them. As a result, beneficiaries experiencing access problems may choose not to pursue such hearings.

To strengthen its oversight of Reform plans, AHCA developed a centralized database for receiving and tracking complaints specific to Reform plans in October 2007. This database contains complaints submitted by beneficiaries, advocates, and providers through the Choice Counseling program, the Medicaid area offices, and AHCA headquarters offices. In May 2008, AHCA staff began meeting monthly to review these complaints to identify problems that Reform beneficiaries have experienced, including difficulties related to accessing specialty providers needed to treat their health conditions. While this oversight activity may assist AHCA to focus on concerns specific to Medicaid Reform provider network adequacy and accessibility, this database relies on beneficiaries knowing that they can report problems to places other than their health plans. [10]

To better ensure that Reform provider networks meet beneficiary needs, AHCA should develop additional Reform contract requirements as well as improve its oversight of provider networks. For example, to ensure there are sufficient providers available to meet beneficiary needs, AHCA could establish benchmarks for patient to specialty physician ratios, especially for those physicians that treat chronic conditions prevalent in the Medicaid population. [11] To strengthen its oversight of provider network adequacy and to ensure that specialty providers are accepting new patients, AHCA could also periodically review the provider networks across all Reform plans in each pilot county to identify which providers participate in more than one plan. This information would better ensure that Reform providers have the capacity to address the needs of beneficiaries in each Reform area.

[6] These annual reviews essentially update the information that plans are required to submit in their original managed care plan applications.

[7] Quarterly grievance reports include both appeals and grievances. Appeals relate to actions by the plan or providers, such as the denial of a service. Grievances relate to other beneficiary concerns, such as complaints about being treated rudely.

[8] The fair hearings, which include the Subscriber Assistance Program, Beneficiary Assistance Program, and Medicaid Fair Hearings, are external grievance processes that beneficiaries can pursue when they are not satisfied with their health plan's decisions.

[9] These reports provide aggregate information on the number of complaints and appeals that a plan processes, how long it takes to resolve the issues, and how the issues are resolved. Beneficiary complaints and appeals are reported by broad categories such as benefits and services and enrollment and disenrollment.

[10] The member handbooks that health plans send to beneficiaries when they enroll are required to include information on how to address complaints or problems.

[11] In discussing this recommendation with AHCA staff, they indicated that they have begun to explore developing benchmarks for some specialty areas.

Is information provided to beneficiaries on Reform provider networks accurate and sufficient to help them select a health plan to meet their needs?

A major reason cited by Medicaid Reform beneficiaries for selecting a health plan is that it would allow them access to specific providers. However, the provider information beneficiaries receive from choice counselors or plans is not always accurate and can be difficult to use. As a result, beneficiaries cannot depend on the information they receive to help them select a plan that meets their health care needs and enables them to get appointments to see desired providers.

Beneficiaries primarily receive information about the providers that participate in Reform plans from choice counselors and plans' provider directories.[12] To help answer beneficiaries' questions, choice counselors electronically access provider network files that Reform plans submit to AHCA.[13] Beneficiaries may also obtain information about the Medicaid Reform plans' provider networks from directories that plans must post on their websites or from published directories that plans must mail to new enrollees.

However, stakeholders and independent researchers have noted that beneficiaries have experienced problems obtaining and using information about the providers that serve specific health plans.[14] Stakeholders and studies have reported that the information beneficiaries receive from choice counselors and plan websites about provider networks can be outdated, and provider directories are not always available on plans' websites. As a result, some beneficiaries have reported that they selected plans based on the participation of specific providers only to discover that the providers they sought were no longer participating in the plan or were not accepting new patients. In addition, disenrollment data from October 2006 to June 2008 shows that 24% of the beneficiaries who disenrolled from a Reform plan did so because their primary care or specialist physician was not in the plan in which they enrolled.[15]

To address these concerns, in March and April 2008 AHCA contacted a sample of providers listed in the provider network files to confirm participation in Reform health plans.[16] In instances where AHCA could not confirm or reach a provider, staff followed up with the health plan to determine if it contracted with the provider; if non-participation was confirmed, staff corrected the plan's electronic network file. In addition, AHCA requires plans to update their on-line directories each month and to send updated directories to all enrolled beneficiaries once every six months or when requested.[17]

Our review of plans' electronic provider network files and websites indicates that beneficiaries may still encounter difficulties when selecting a Reform plan based on provider network information from choice counselors or posted on plans' websites. We examined these data sources between May and August 2008 and found that the information provided was difficult to access and use in selecting a Reform plan. For example, the provider network files used by choice counselors only indicate whether primary care providers are accepting new patients; AHCA does not require this information for specialists or other providers. In addition, the Reform plans' websites use

[12] Choice counselors assist beneficiaries to select and enroll in a Reform health plan.

[13] These files contain information about the providers that participate in each plan, including name, gender, address, languages spoken, and the type of services provided, such as practice specialty.

[14] Stakeholders include staff of advocacy groups and participants in beneficiary focus groups held by independent researchers and persons attending Medicaid Reform town meetings hosted by AHCA. Studies we reviewed included a program review conducted by AHCA's Office of the Inspector General and several studies conducted by Georgetown University under contract by the Jessie Ball DuPont Fund to evaluate Medicaid Reform.

[15] Choice counselors select from among 25 categories for the reason why beneficiaries are disenrolling from a plan within their 90-day window, which includes the category 'other'. Of the 43,154 beneficiaries who voluntarily disenrolled or requested a plan change within 90 days between October 2006 and June 2008, 56% selected the 'other' category.

[16] AHCA staff attempted to survey 117 providers in Broward during March 2008 and 117 providers during April 2008 in AHCA Area 4 that includes four pilot counties (Baker, Clay, Nassau, and Duval) plus three other counties (Flagler, St. Johns, and Volusia), contacting 39 providers for each of the following provider types: dentists, individual specialty providers, and primary care physicians. This survey is part of a larger ongoing statewide effort (not specific to Reform) to assess and improve the accuracy of all managed care plans' provider network files.

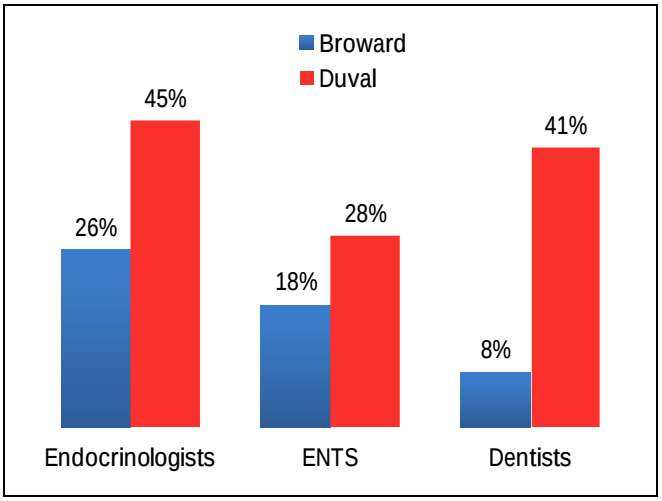
[17] In addition, AHCA requires plans to send written notice within 15 days to any beneficiary who receives regular care from a provider that leaves the plan's network.

different formats for giving information about their providers, with some providing electronic lists while others use search engines requiring beneficiaries to conduct queries of specific providers or specialties. The search engines also vary, with some requiring beneficiaries to input zip codes and others requiring them to search by provider name or specialty type. As a result, it can be difficult and confusing for beneficiaries to obtain the information they need to help them select a health care plan, which can be of particular importance to beneficiaries who need specialty care to treat chronic conditions.

Our assessment of provider directories in Broward and Duval counties also indicated that some listed specialty providers are not available to serve Reform beneficiaries. We obtained the provider directories for 11 Reform plans in Broward County and 6 in Duval County, and between June and July 2008 attempted to contact each of the listed endocrinologists, otolaryngologists (commonly known as Ear, Nose, and Throat specialists, or ENTs), and dentists to verify their plan participation. [18, 19]

As shown in Exhibit 1, in Broward County, we were unable to reach a quarter of the endocrinologists, approximately a fifth of the ENTs, and 8% of the dentists using the phone numbers listed in the health plans' provider directories. In Duval County, we were unable to contact almost half of the endocrinologists, a quarter of the ENTs, and 41% of the dentists that we attempted to call. In instances when we were unable to reach providers, the telephone number listed in the provider directory was a wrong number or had been disconnected, the call was not answered after multiple attempts, or the call was answered but we were placed on hold for five minutes or longer. In addition, in both Broward and Duval, we were unable to learn if some listed dentists were accepting new patients despite having reached their offices. [20]

Exhibit 1
Some Specialists Listed in Plans' Provider Directories Could Not Be Reached [1]



[1] In Broward County, our survey population included 90 listings for endocrinologists, 129 listings for ENTs, and 169 listings for dentists. In Duval County, our survey population included 55 listings for endocrinologists, 78 listings for ENTs, and 69 listings for dentists. Source: OPPAGA telephone survey of Medicaid Reform health plans' providers conducted in June and July 2008.

[18] We selected these specialty providers based on their importance to the Medicaid population. Many beneficiaries suffer from diabetes and are treated by endocrinologists. Similarly, many children with ongoing ear infections require treatment by otolaryngologists, and Medicaid beneficiaries have historically had difficulty accessing dental services.

[19] We asked each of the Reform plans serving Broward and Duval counties to send us their most recent provider directories. We received directories from 11 of the 16 Broward County plans and 6 of the 7 Duval County plans. The provider directories for three of these Broward County plans and one Duval County plan did not include dental providers because these plans subcontracted dental services to a separate dental plan. We attempted to call each of the endocrinologists, otolaryngologists, and dentists listed in the Reform plans' directories, for a total of 252 unique providers which represented 590 providers listed in the health plans' directories.

[20] This typically occurred because the listed providers worked at a public health clinic that did not provide information about individual dentists or because these services were coordinated through a dental provider that subcontracted with the Reform health plan.

Of those specialty providers that we were able to reach, some reported they were not accepting new patients or were only accepting patients under specific circumstances. For example, as shown in Exhibit 2, in Broward County, one-third of the ENTs that we reached were not accepting new Medicaid Reform beneficiaries; in Duval County, one-fifth of the ENTs that we reached were not accepting new Reform beneficiaries. In addition, some providers in both counties restricted services to Reform beneficiaries in some way. In Broward County, 13 ENTs were accepting patients only if they had a specific diagnosis, were referred by another ENT, were children, or at a certain location; in Duval County, 5 ENTs were accepting beneficiaries only on a case by case basis or with a certain diagnosis. Our call survey results suggest that AHCA should take additional steps to ensure that Medicaid Reform plans provide accurate information to their beneficiaries.

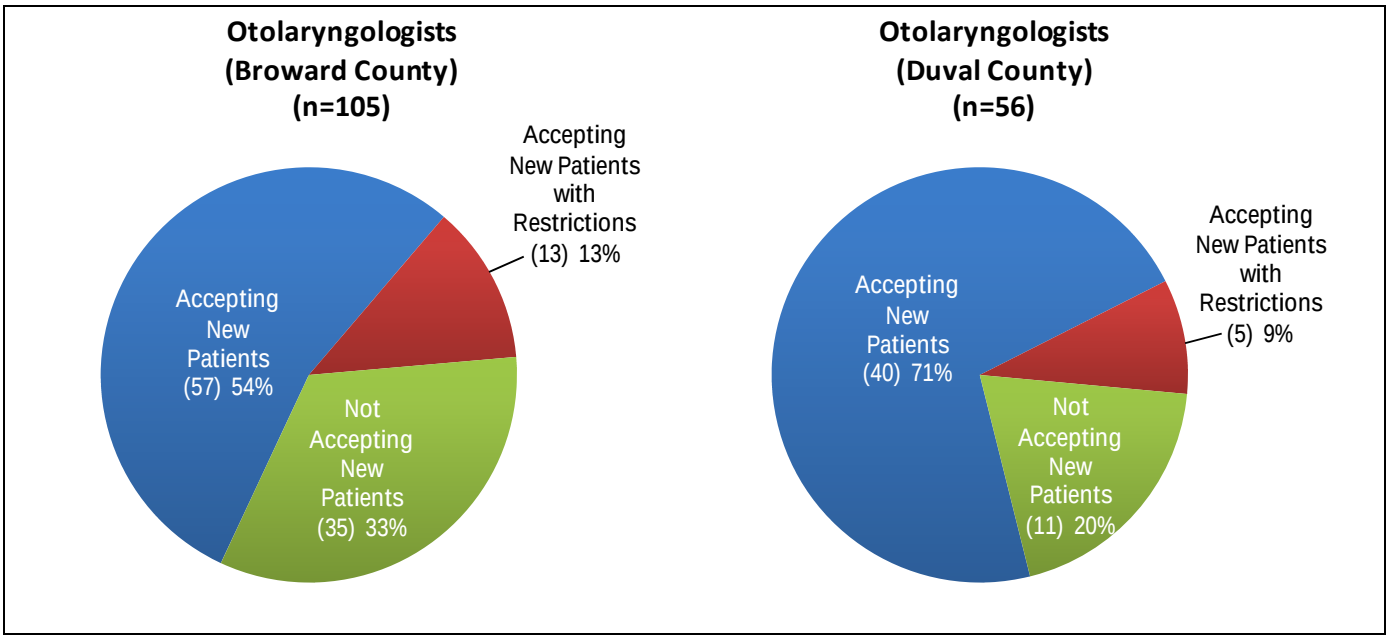
Has access to specialty providers improved under Medicaid Reform?

While improving access to health care specialists is a major objective of Medicaid Reform, to date there is conflicting evidence to support whether or not this has occurred. AHCA has conducted an analysis on whether access to five types of specialists in Duval County—dermatologists, neurologists, orthopedists, dentists, and pain management providers—has improved.[21] AHCA concluded that access to these specialists either had improved in June 2007 compared to June 2006, or was more than adequate to meet the needs of Duval County's Medicaid Reform beneficiaries.[22] However, this analysis did not address whether beneficiaries could obtain appointments to see these specialists in a reasonable amount of time, and data available from other sources indicates that access to specialists can be problematic.

[21] A summary of this analysis can be found in AHCA's second annual report on Florida's Medicaid Reform submitted to the Centers for Medicare and Medicaid at http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/pdf/reform_final_annual_report_yr2_070107-063008.pdf.

[22] AHCA concluded that access was improved in June 2007 compared to June 2006 for dermatologists, neurologists, and orthopedists. AHCA also concluded that even though access did not improve for dentists and pain management providers, access was more than adequate in June 2007.

Exhibit 2
From One-Fifth to One-Third of the ENTs That We Reached Were Not Accepting New Reform Beneficiaries



Source: OPPAGA telephone survey of Medicaid Reform health plans' providers conducted in June and July 2008.

AHCA based its conclusion that access improved by comparing the number of listed providers per 100,000 Medicaid beneficiaries for dermatologists, neurologists, orthopedists, dentists, and pain management services. Because the number of listed providers in these specialty areas had increased or compared favorably to AHCA's estimate of need in these areas, AHCA concluded that access had improved or was adequate to meet beneficiaries' needs.

However, AHCA's results do not show whether the providers were serving Reform beneficiaries and/or whether new beneficiaries could get appointments to see them within reasonable timeframes. For example, our survey of endocrinologists, otolaryngologists, and dentists in Duval and Broward counties indicated that beneficiaries could face long waits for appointments. In Duval County, new Reform beneficiaries seeking an appointment to see an endocrinologist could wait up to four months regardless of the plan they selected; in Broward County wait times for appointments could be as long as 11 months. Long wait times would not meet AHCA's contract standards and could compromise the health of beneficiaries who need specialty care.

Information from other sources also indicates that access to specialists can be problematic for Medicaid Reform beneficiaries. Advocacy organizations note that beneficiaries have reported problems when trying to make appointments with specialists. In addition, half of the 229 complaints from Reform beneficiaries received by AHCA during Fiscal Year 2007-08 were related to difficulties obtaining referrals to specialty providers and/or authorization for these services.

AHCA's ability to assess whether access to specialists has improved under Reform has been constrained by lack of data on the services provided to Medicaid beneficiaries (termed "encounter data") and duplicate provider identification data in the provider network electronic files. [23] AHCA is working to develop a Medicaid encounter data system and is helping Medicaid Reform plans submit valid encounter data. [24] However, the system is not expected to be fully operational until fall 2009. To help address the problem of duplicate provider identification data, AHCA's contracts with managed care plans require that all providers obtain a unique national provider identifier by May 2008. While this should help improve data accuracy, AHCA staff indicates that all plans are not yet in compliance with this requirement.

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration for her review and response.

The Secretary's written response has been reproduced in Appendix B.

[23] The provider network files included information about individual providers multiple times both within single Reform plans and across several Reform plans within a pilot area. However, because most plans were not using the unique provider identification number, it was not possible to determine an accurate count of unique providers.

[24] The system is called the Medicaid Encounter Data System and will collect, process, store, and report on managed care service utilization for all Florida Medicaid capitated health care providers.

Appendix A

AHCA Uses the Same Requirements for Both Reform and Non-Reform Health Plans' Provider Networks

AHCA requires that Reform health plans meet the same contract requirements related to developing provider networks as it does traditional Medicaid managed care plans. These standards are intended to ensure that Medicaid managed care plans have sufficient numbers of primary care and specialty providers as well as facilities, such as hospitals and birthing centers, to meet the needs of the beneficiaries expected to be served by their plans. AHCA's contract with both Medicaid Reform and non-Reform health plans also include requirements for wait times and distances that beneficiaries must travel in order to see a provider. AHCA may waive some of these requirements for rural areas.

Table A-1
AHCA Requires Health Plans to Maintain Certain Provider Network Standards

Provider/Facility Type	Minimum Requirement [1]
Primary Care Provider	One per county per 1,500 enrollees; primacy care providers include specialties known as family practice, general practice, obstetrics and gynecology, pediatrics, and internal medicine
Specialists	Plan shall assure access for adults and children on at least a referral basis; required network specialists include: allergist, anesthesiologist, cardiologist, chiropractic physician, dermatologist, endocrinologist, gastroenterologist, general surgeon, infectious disease specialist, nephrologist, neurologist, neurosurgeon, obstetrician and gynecologist, oncologist, ophthalmologist, optometrist, oral surgeon, orthopedist, otolaryngologist, pathologist, podiatrist, psychiatrist, pulmonologist, radiologist, therapists (physical, respiratory, speech and occupational), and urologist.
Behavioral Health - Outpatient	One each board certified adult and child psychiatrist; one direct service provider per 1,500 enrollees.
Behavioral Health - Inpatient	One accredited psychiatric community hospital bed per 2,000 enrollees, including as needed for medical detoxification treatment
Behavioral Health Case Management	One per 20 children, and one per 40 adults
Acute Care Hospital [1]	One fully accredited bed per 275 enrollees
Emergency Services	Must be available 24 hours/ day, seven days/week
Birth Delivery Facility	One licensed facility per plan; may be part of a hospital or freestanding birthing center
Birthing Center	One licensed center per plan
Certified Nurse/Licensed Midwife Services	Plan shall ensure access as appropriate
Regional Perinatal Intensive Care Center	One or more per plan; may also include a hospital with licensed Neonatal Intensive Care Unit Level III beds
Neonatal Intensive Care Unit	Plan shall ensure care at appropriate level
Pharmacy [1]	One licensed pharmacy per 2,500 enrollees (This is required if the health plan elects to use a more restrictive pharmacy network than non-Reform fee-for-service network.)
Public Health Services	Plans must execute memoranda of understanding with county health departments; required public health services include family planning services, treatment of sexually transmitted diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and Healthy Start screenings.

Table A-1 (Continued)

Appointment Wait Times	Requirement
Urgent Care	Within one day (Urgent care is defined in the contract as services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received, e.g., high fever, animal bites, fractures, and severe pain, or do substantially restrict an enrollee's activity, e.g., infectious illnesses, flu, and respiratory ailments.)
Routine Sick Patient Care -	Within one week (Sick care is defined in the contract as non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated, e.g., chronic disease).
Well Care Visit	Within one month (Well care visit is defined in the contract as a routine medical visit for the following: Child Health Check-Up Program visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals, or any other routine visit for other than the treatment of an illness.)
Geographic Access Standards	**Requirement**
Primary Care Physicians and Hospitals	Within 30 minutes travel from enrollees' residence
Specialists and Ancillary Services	Within 60 minutes travel from enrollees' residence
Emergency Services Facility	Within 30 minutes travel from enrollees' residence
Pediatrician, County Health Departments, Federally Qualified Health Centers, and/or Rural Health Clinics	Within 30 minutes travel from enrollees' residence

[1.] AHCA specifically developed this standard for Reform contracts and decided to also include them in the non-Reform contracts.
Source: OPPAGA analysis of AHCA Reform and non-Reform model health plan contracts.

Appendix B

CHARLIE CRIST
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

November 25, 2008

Gary R. VanLandingham, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
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Dear Mr. VanLandingham:

Thank you for the opportunity to review the draft report entitled: *"Medicaid Reform: Reform Provider Network Requirements Same as Traditional Medicaid; Improvements Needed to Ensure Beneficiaries Have Access to Specialty Providers."*

The Agency would like to thank OPPAGA for their diligent efforts to understand the Agency's oversight process of health plans in the pilot regarding provider network requirements. As always, we appreciate the opportunity to respond and look forward to working with OPPAGA again in the future.

Sincerely,

Holly Benson
Secretary

HB/co

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