



Schneider
Medicaid

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

February 14, 2008

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)

The Honorable Henry Waxman
Chairman, House Committee on Oversight and Government Reform
2157 Rayburn House Office Building
U.S. House of Representatives
Washington, DC 20515-6143

Dear Chairman Waxman:

This is in response to your letter of January 16 requesting information on the impact of 7 recent CMS Medicaid regulatory actions on states and beneficiaries. The Department of Medical Assistance Services (DMAS) is the single state agency responsible for the administration of the Medicaid program in Virginia. Attached are DMAS comments to CMS on 5 of the 7 regulations and a summary of the fiscal impact, the impact on beneficiaries and other comments on each of the regulations. DMAS welcomes Congressional oversight of these regulations.

One cost that is not quantified is the administrative burden on the State Medicaid agency and many providers to implement these regulations. These costs may be worthwhile if they represent an improvement in policy. In some cases, however, much of the policy embedded in the regulation is dubious or pointless. In other cases, the regulations represent a reversal of longstanding policy, such as Medicaid reimbursement for GME or school administrative costs. DMAS would also expect unforeseen consequences.

DMAS understands that comments to CMS on these regulations have been overwhelmingly negative, yet CMS, to judge by those regulations that have been finalized, is unlikely to withdraw the regulations or consider substantive changes. Congress has placed temporary moratoriums on some of these regulations and is considering additional moratoriums. It is our hope that Congressional review will be more responsive than CMS has been to concerns of state Medicaid agencies, Medicaid beneficiaries and Medicaid providers.

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick W. Finnerty".

Patrick W. Finnerty

PWF/wjl
Enclosures

Impact of Recent Federal Rules on Virginia Medicaid (Department of Medical Assistance Services or DMAS)

Federal Rule	Federal Fund Impact by SFY	Effect on Medicaid applicants and beneficiaries	Other Comments
Cost Limits for Public Providers (final with comments)	SFY09 \$1,387,000 SFY10 \$1,456,350 SFY11 \$1,529,168 SFY12 \$1,605,626 SFY13 \$1,685,907	Possible loss of services furnished by some small government providers who find the cost of a cost report outweighs the reimbursement received.	The rule will expand the number of cost reporting providers who have little experience in cost reporting to no benefit.
Payment for Graduate Medical Education (proposed)	SFY09 \$15,447,634 SFY10 \$16,220,016 SFY11 \$17,031,017 SFY12 \$17,882,567 SFY13 \$18,776,696	DMAS believes that paying for GME benefits Medicaid beneficiaries.	DMAS could offset the fiscal impact to private hospitals by increasing hospital rates by an equal amount, but not necessarily distributed in the way that serves the same purpose. About one-third, however, is for public hospitals to whom we cannot pay any more.
Payment for Hospital Outpatient Services (proposed)	N/A	N/A	
Provider Taxes (proposed)	N/A	N/A	Virginia does not have provider taxes.
Coverage of Rehabilitative Services (proposed)	Undetermined	Some long-term services may no longer be considered rehabilitation services.	If necessary, DMAS intends to convert rate units in a budget neutral manner.
Payments for Costs of School Administrative and Transportation Services (final)	SFY09 \$25,120,773 SFY10 \$26,376,812 SFY11 \$27,695,652 SFY12 \$29,080,435 SFY13 \$30,534,457	N/A	Helps finance the federal government special education mandates.
Targeted Case Management (CM) (interim final)	Undetermined. If transportation is eliminated from coverage under Medicaid, costs may shift to state or local funds.	<ol style="list-style-type: none"> 1. Elimination of transportation may result in some recipients not receiving services. 2. Some recipients receive multiple CM services. It will be very difficult to furnish the same level of services using one case manager who is not trained in all problems. 	DMAS intends to convert rate units in a budget neutral manner.



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March 19, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-2558-P

Dear Ms. Norwalk:

DMAS is commenting on the proposed rule published January 18, 2007 on the "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership." DMAS is the single state agency responsible for the administration of the Medicaid program in the Commonwealth of Virginia. DMAS opposes the proposed rule and strongly urges CMS to withdraw it.

DMAS does not believe that the proposed rule is necessary in any way to ensure the integrity of the federal-state financial partnership. Over the last several years, CMS has addressed the issues it is concerned about in regards to certain intergovernmental transfers and certified public expenditures. The rule unreasonably interferes with the state determination of public entities and unfairly discriminates against those public entities. The proposed rule unreasonably limits reimbursement to public providers and imposes unnecessary cost reporting requirements on public providers. The proposed rule is far reaching and would have unintended consequences.

Determination of Government Providers

Despite careful efforts to read Sec. 433.50 of the proposed rule, DMAS cannot determine whether some providers will be determined to be "government units." Several traditional "public" providers do not appear to meet the definition. It appears possible

that the rule may also create inconsistent treatment among similar providers. In Virginia, for example, mental health authorities may be organized in three different ways authorized by the Code of Virginia. As a result, DMAS cannot determine whether all, some or none of the mental health authorities in Virginia will be considered government units. In some ways, however, the proposed rule is so broad that it would include even county or city ambulance services that provide emergency transportation.

It appears that CMS will make the final determination if a provider meets the new definition of a government unit, but it is not clear how a provider, or the state, could appeal the determination. Such a determination could have a significant positive or adverse impact on a provider depending on the provider's circumstance and there should be an avenue of appeal.

Limitations on Reimbursement for Government Providers

During the last few years, CMS has asked states five funding questions during every review of a SPA related to reimbursement. The last question asks if any public provider receives payments that in the aggregate exceed their reasonable cost of providing services and, if they do, does the state recoup the excess. DMAS' response indicated that this was not required by Federal law or regulation. While CMS may modify its regulations, it has not demonstrated that payments that exceed reasonable costs are "excess" payments.

The current UPL for government providers of inpatient and outpatient hospital, nursing home, ICF-MR and clinic services is what Medicare would have paid. For other services, CMS has limited reimbursement to what commercial insurers pay based on Sec. 1902(a)(30) of the Social Security Act that payments should be consistent with efficiency and economy. Neither standard is based on costs. CMS does not propose to change the upper payment limit for private providers. The current UPL seems perfectly reasonable to DMAS. We don't understand why what is acceptable for Medicare is too generous for Medicaid. It seems like the existing UPL is a perfectly reasonable upper payment limit for both public and private providers and there is little justification for changing it.

There are certain areas of reimbursement such as physician fees that have little or no history of using costs as a benchmark for reimbursement. A substantial portion of DMAS reimbursement to local health departments is based on the DMAS physician fee schedule. DMAS only pays approximately 70% of what Medicare pays for physician fees.

Many payers, both government and private including Medicare, have invested extensive resources in developing prospective payment systems because they are inherently more efficient and cost effective. Under such systems, efficient providers may earn a "profit." Paying government providers the lower of cost or the prospective rate is unfair and undermines the prospective payment system. In fact, DMAS believes it likely that public providers will insist that they be paid cost if this rule becomes final.

In most cases, the reimbursement methodology makes no distinction between public and private providers. It seems unnecessary to impose additional requirements on government providers who are being treated exactly the same as private providers.

There are circumstances when Medicaid payments, including DSH, are used to cover the uninsured. Limiting Medicaid reimbursement to costs will make it difficult to fund uninsured care provided by the state teaching hospitals. DMAS will not be able to shift costs to DSH because of caps on Virginia's DSH allocation. While Congress placed limits on DSH allocations to States ten years ago, we believe that Congress understood that States have different arrangements for financing uncompensated care and it did not envision additional Medicaid regulatory reductions that would jeopardize the capacity of States to cover uncompensated care costs.

Cost Reporting Requirements

The proposed rule will require many providers who are government units to submit cost reports for the first time. We believe that this will create an unnecessary hardship on these providers for no good purpose since many will not have costs that exceed reimbursement. If the proposed rule is finalized, we would urge CMS to include a basis for exemption to the cost reporting requirements. The exemption could be related to the extent to which public providers are a significant percentage of the total providers using the same reimbursement methodology, a dollar reimbursement threshold or a demonstration that reimbursement in the aggregate does not exceed cost. As one provider indicated to DMAS, it adds insult to injury to require cost reporting when DMAS pays only 70% of what Medicare pays for physician services, for example.

One of the advantages of prospective payments systems is to reduce the level of effort on both the provider and government to prepare and audit cost reports. Over the years, DMAS has reduced the number of providers who must file cost reports and has substantially reduced the resources needed to audit cost reports. The proposed rule will greatly expand the number of providers who must file cost reports. To the extent that certain providers have limited capacity for preparing cost reports, they may decide that furnishing services to Medicaid recipients is not worth it. DMAS is particularly concerned about the burden on small local health departments that often play a key role in providing access in underserved areas. DMAS currently spends less than half a cent on auditing for each dollar of reimbursement. Under the proposed rule the auditing cost per dollar of reimbursement could increase significantly.

Certified Public Expenditures

DMAS contracts with several state agencies for Medicaid administrative services. The state share is appropriated directly to these agencies and DMAS "passes through" the federal share. It is unclear whether this is considered a certified public expenditure.

Retention of Payments

This new section appears particularly unnecessary. To the best of our understanding, CMS has eliminated the "recycling" of funds and the purpose of the regulation is to formalize the current practice, not to accomplish anything new. We, like others, are concerned, however, that the regulation may have unintended consequences by potentially limiting transactions between parties that clearly are not problematic.

Implementation

While DMAS strongly encourages CMS to withdraw the proposed rule, if it is finalized, CMS must address issues related to the implementation of the rule. First, DMAS cannot implement this rule on September 1, 2007 if it does not know in advance who qualifies as a government unit under the rule. It may seem self evident to CMS, but it is not self-evident to DMAS and the public providers DMAS has consulted with. Second, implementing cost reports for some providers may take a considerable time to develop. DMAS has been working with CMS for several years to develop a cost report for school providers. Third, DMAS may need to consider alternative financing for certain providers if the current reimbursement exceeds costs. DMAS does not know whether costs exceed reimbursement for some providers, if they are currently not required to file cost reports.

In conclusion, DMAS appreciates the opportunity to comment on the proposed rule. We do not believe the proposed rule is necessary to ensure the integrity of Federal-State financial partnership. In fact, we believe that it will harm the Medicaid program and the people we serve. We urge CMS to withdraw the proposed rule.

Sincerely,



Patrick W. Finnerty

PWF/wjl



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Department of Medical Assistance Services

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June 5, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-2279-P

Dear Ms. Norwalk:

DMAS is commenting on the proposed rule published May 23, 2007 on the "Medicaid Program; Graduate Medical Education." DMAS is the single state agency responsible for the administration of the Medicaid program in the Commonwealth of Virginia. DMAS opposes the proposed rule and strongly urges CMS to withdraw it.

DMAS questions how CMS can simply "clarify" that payments associated with Graduate Medical Education (GME) are no longer federally reimbursable under the Medicaid program when it has participated in state Medicaid GME payments since the beginning of the Medicare and Medicaid programs, more than forty years ago. Like most states, Virginia reimbursed GME costs because it used Medicare cost reports to determine reimbursable costs. Virginia now reimburses Medicaid GME using a prospective payment methodology previously approved by CMS. Since almost all states reimburse for GME under their Medicaid programs, it is obvious that CMS has reviewed and approved Medicaid reimbursement of GME countless times over a long period. We are also not aware of any reports by the Government Accounting Office or the Office of the Inspector General that question Medicaid payments for GME.

DMAS reviewed the background for the proposed rule and did not see the relevance of this background material to the proposed rule. The extensive discussion of Medicare GME reimbursement being a "supplemental" payment does not seem relevant to the appropriateness of Medicaid reimbursement for GME. Medicare has always paid

Ms. Leslie Norwalk
June 5, 2007
Page 2

for its share of GME despite past efforts, referred to in the background, “by the Congress and this agency to substantially limit or eliminate Medicare GME subsidies.” In the end, the fact that Medicare still pays for GME would seem to strengthen rather than weaken the rationale for Medicaid to also pay for GME.

CMS asserts that Medicaid GME funding does “not necessarily” achieve its goals or that there is “generally no assurance” that it does, but does not provide any evidence that Medicaid GME funding is not effective in “supporting these programs or in furnishing any benefit to Medicaid program beneficiaries.” Indeed it seems self-evident that the provision of significant funding to educational programs could not help but support those programs, and it seems equally clear that the withdrawal of that funding will hurt those programs. It also seems clear that Medicaid recipients benefit from the provision of an adequate supply of physicians, though admittedly GME is not a direct service cost.

Virginia believes that CMS has provided no convincing evidence that GME reimbursement by Medicaid is not a useful and beneficial part of the program, or that the elimination of that funding will not cause significant harm to the preservation of a physician work force.

In conclusion, DMAS appreciates the opportunity to comment on the proposed rule. We do not believe that it is appropriate to eliminate Medicaid funding of GME. We urge CMS to withdraw the proposed rule.

Sincerely,

A handwritten signature in cursive script, appearing to read "P. W. Finnerty".

Patrick W. Finnerty

PWF/wjl

Docket Management Comment Form

Docket: CMS-2261-P - Rehabilitation Services: State Plan Option

Temporary Comment Number: 213055

Submitter:	Ms. Cindi Jones	Date:	10/11/07
Organization:	Dept. of Medical Assistance Services		
Category:	State Government		
Issue Areas/Comments			
Provisions of the Proposed Rule Provisions of the Proposed Rule			
<p>On page 45205 of the CFR (last paragraph of section F.1.), it states that if a state desires to cover Rehabilitative Services, it must amend its State Plan in accordance with the (new) 42 CFR 441.45(a)(5). Does CMS expect states already in compliance to submit a new State Plan Amendment? The proposal requires that the State Plan describe the services, specify provider qualifications, and specify the payment methodology. State Plans are already required to specify the payment methodology. Will these proposed regulations be used as the authority for changing from payments for an entire program to 15 minute payments for a specific provider? The proposed regs state that the provider must keep a record of who delivers services and the amount of time. It doesn't state that this must be the basis for payment. Does having a payment methodology specified in the current State Plan meet the requirement or must the methodology be based on the specific provider and the exact amount of time the service is provided? This specificity in billing can be an administrative burden for providers. Can a state meet the requirement that the client must sign the plan of care through guidance documents or must it be in the State Plan to be in compliance with the proposed regulation? Additionally, providers are concerned about the statement on page 45204 of the CFR that states that maintaining function in order to achieve a rehabilitation goal is allowed, but maintaining function in and of itself rather than being directed at a rehabilitation or recovery goal is not allowable. Providers are concerned that the service might be denied as progress may be in small increments over a longer period than the review period (e.g., measurable over a two-year retrospective, but not over last twelve months). Can CMS provide further guidance on this point?</p>			
Attachments			
No Attachments			



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November 5, 2007

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-2287-P

Dear Mr. Weems:

DMAS is commenting on the proposed rule published September 7, 2007 on the "Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School." DMAS is the single state agency responsible for the administration of the Medicaid program in the Commonwealth of Virginia. DMAS opposes the proposed rule and strongly urges CMS to withdraw it.

Public schools in Virginia are partners with the state Medicaid agency. They assist in outreach to insure that all eligible children have access to Medicaid health insurance. Public schools also assist current Medicaid recipients in accessing health care services. Under this rule, DMAS would be able to contract with all other public agencies, but not with school divisions.

The first argument that CMS makes is that these activities "are not necessary for proper and efficient administration of the state plan" because they "largely overlap with educational activities that do not directly benefit the Medicaid program." What is important is that these activities do directly benefit Medicaid recipients in accessing health care services. CMS acknowledges that "the proposed rule does not bring into question the legitimacy of the types of Medicaid administrative activities provided in schools." State agencies would provide many services even without Medicaid matching funds, but their ability to provide the same level of service would be limited. Public school divisions are no different.

The second argument that CMS makes is that “such activities can only be properly conducted, overseen and appropriately allocated to Medicaid when conducted by employees of the State or local Medicaid agency.” In our mind, there is no question that Medicaid administrative activities can be properly conducted, overseen and appropriately allocated to Medicaid when conducted by public school employees or contractors. There are certainly examples where there have been problems, but for the most part Medicaid agencies are providing the necessary oversight and fiscal management. This is in part thanks to efforts by CMS to provide consistent guidance.

In 2003, CMS issued updated guidance on administrative claiming and time studies. DMAS has recently worked with CMS for over nine months on approval of a new time study to be used for both administrative claiming and direct services. State participants involved in this exercise believe that it will accurately reflect the time and effort schools furnish to Medicaid administrative activities. We would expect that CMS staff would agree.

The proposed rule refers to concerns expressed at Congressional hearings that were seven or more years ago. The Medicaid Fact Sheet distributed with the proposed rule cites GAO and OIG audits that no longer give an appropriate picture of today’s situation. CMS has responded to these concerns and audits by improving its oversight of school services. It doesn’t make sense to throw out the investment CMS has made in oversight of school services. Eliminating Medicaid payments for school-based administration and transportation is an overreaction.

The title of the Medicaid Fact Sheet reads, “CMS Proposes Improvements to Payments for School-Based Administration and Transportation.” Later in the Fact Sheet it says that CMS issued the proposed rule “to ensure that the Medicaid program meets its intended goal of assuring coverage and access to care for children and other identified populations.” While the rule may claim to address fraud, waste and abuse in the Medicaid program, it cannot possibly claim to do anything to assure coverage and access to care for children. DMAS cannot replace the activities performed by school divisions to the benefit of Medicaid eligible students.

In conclusion, DMAS appreciates the opportunity to comment on the proposed rule. We believe that this rule is an overreaction to perceived problems in the past. Eliminating coverage for administrative claiming and transportation services does not improve services to Medicaid recipients. It does just the opposite. DMAS urges CMS to address any specific problems in either regulations or policy rather than finalize the proposed rule.

Sincerely,



Patrick W. Finnerty

Submitted electronically

February 4, 2008

FILE CODE: CMS-2237-IFC

Dennis G. Smith, Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Mr. Smith:

The following comments are submitted by the Virginia Department of Medical Assistance Services on the Interim Final Rule for Medicaid Optional State Plan Case Management Services, published in the Federal Register on December 4, 2007.

Transition Case Management (440.169(c) and 441.18(a)(8)(vii)-(viii))

The new regulations establish limits on the period for which case management costs may be claimed based on the length of stay. This limitation does not recognize that housing is a major barrier to transitioning individuals to community settings which often requires much longer than 60 days to arrange.

Transitioning long-stay individuals to the community requires significant work, including application for and access to benefits, finding housing and arranging up support services. This frequently can take more than 60 days. This change is not supported by a statutory change, therefore, I urge CMS to utilize the previous policy of allowing 180 days.

States may not pay for CM if other programs cover, such as foster care or Part C (42 CFR 441.18)

The issue should not be the provider, but the service that is provided. Child welfare workers are not generally health care workers, but if specially trained to manage a child's mental health and related services, there is no reason they cannot be a qualified Medicaid provider of case management. Additionally, children in Part C meet the Medicaid definition for medically necessary case management services. It is unclear what is meant

by “integral” but this restriction may prevent access to needed services for Part C children.

May not condition CM service on the receipt of other services or vice versa (42 CFR 441.18)

The prohibition against case managers serving as gate keepers is problematic as case managers may have the responsibility and authority to authorize services, approve individual plans and determine individual budgets. It would seem that assessing individual needs and developing the plan fall within accepted activities. It is not clear if this provision applies only to State plan services or all Medicaid services, and if the later, it could prevent Money Follows the Person, Part C, and other case managers from authorizing transition services or home and community based waiver services. States should have the ability to designate the approval of services to case managers.

Right of Refusal §441.18(a)(3)

The interim final rule under 441.189a0(3) requires that states “not compel an individual to receive case management services, condition the receipt of case management (or targeted case management) services on the receipt of other services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.” This provision limits the state’s ability to provide coordinated assessment and planning to assure the services are needed, appropriate and providing the intended outcomes. This is also concerning as case managers are the frontline for assuring the health, safety and well-being of individuals served by other providers and organizations. If the individual refuses case management services, this limits the states ability to oversee the care provided.

Payment Methodology (§441.18(a)(8)(vi))

The rule requires case management services to be billed in units of service that must not exceed 15 minutes. States should have the flexibility to pay for Medicaid services in the most cost-efficient manner. Detailed recording of interventions and reporting is an administrative burden and is not conducive to high quality and cost-effective care. States should be permitted to submit cost-reimbursement approaches to CMS for approval, and such approaches should allow various forms of payment including daily rates, case rates, per diem rates, etc. provided the methodology for the rate setting is sound and does not result in unnecessary costs to the Medicaid program.

Monitoring compliance with rule (42 CFR 441.18)

Adding Quality Measurements will be an additional requirement. It is unclear if CMS will provide guidance on this requirement. What is the time frame for adding this requirement?

Single Case Manager (§441.18(a)(5))

The rule requires that Medicaid case management services be furnished by only one case manager for each individual, regardless of the complexities of the individual's case.

This shift in policy has the potential for providing inadequate care. It is unreasonable to expect that a mental health case manager, for example, will have the expertise and knowledge to assist an individual with HIV and all other health care needs.

It is recommended that CMS require close collaboration among case managers from different systems for those individuals who have dual diagnoses, each of which is a serious health condition.

This requirement will be problematic for individuals in managed care programs. Targeted case management should be allowed for individuals with specific needs in managed care programs.

It is also unclear if there may be two case managers providing the same type of targeted case management. In other words, can one case manager cover for another or provide services that are complimentary?

Transporting Individuals to Services (440.169)

The background to the rule states that referral and related activities of case managers do not include providing transportation to the service or escorting the individual. This change in policy creates problems and doesn't acknowledge the special needs of persons with serious mental illness. There are two issues: whether a case manager should be able to bill for the time of helping the individual access a necessary service by transporting the person to that appointment, and whether case management services can be furnished during transportation. Since rehabilitation and case management services can be furnished in any setting, it is reasonable to include coverage for case management services provided while a case manager accompanies a person for a service that is included in the plan of care.

Time spent accompanying an individual, but not spent furnishing another specific case management service, should be allowed. Access to non-medical services may not be possible without transportation by a case manager.

Limits on Activities That Can Be Reimbursed As Case Management (441.18)

This is particularly important for Part C service coordination. The elimination of several IDEA Part C functions (IFSP Development, prior written notice, preparing for or conducting the IFSP meeting, scheduling or attending IFSP meeting) as reimbursable will cause Part C service coordinators to absorb this function and limit their capacity to serve children.

Limits Who Can Authorize Services (441.18)

For Part C services, states with a single entry point system may have to unbundle the process for accessing services by allowing community case management agencies to complete the assessment and care plan and designate other staff to determine eligibility, approve the care plan and authorize services. This may delay services for Part C children and will likely reduce the provider's capacity for serving children.

Thank you for considering our comments.

Sincerely,

Patrick W. Finnerty