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NAVAPD NEWS

The Voice of VA Physicians and Dentists Since 1975

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Court Orders VA to Overhaul Mental Health/Disability

On May 10, the 9th Circuit Court of Appeals in Cincinnati turned its ire on the VA, stating that the "unchecked incompetence" by the VA had resulted in "egregious" delays in mental health care and processing of disability claims. In the landmark ruling, the Court ruled that the VA's failures to deliver timely mental health care and disability benefits violated Veterans' constitutional rights and contributed to the despair behind 6,500 annual Veteran suicides.

The VA is required to provide a mental health assessment within 30 days of any veteran's request for help, but many are delayed months or years. Tens of thousands deemed not in need of care are placed on waiting lists because of chronic shortages. The Court determined that Veterans' statutory rights of health care benefits, death benefits, and disability compensation constitute "property interests" protected by the Due Process Clause of the Fifth Amendment.

The court also noted that according to a 2007 report by the OIG, there are no suicide prevention officers at any of the VA's 800 CBOCs, where many if not most veterans receive their care. During the trial, emails between high-ranking VA officials revealed awareness of the high suicide rates among Veterans (an average of 18 per day), and a desire to keep quiet the number of enrolled Veterans who attempt suicide.

Overall, the Court concluded that these delays and shortcomings violate Veterans' Fifth Amendment rights, and ordered that the case be remanded to a lower court to oversee a complete overhaul of the VA health care and benefits system. While critics of this approach say that the Executive Branch should lead the overhaul, the Court said courts must intervene since other branches of government have failed to respond appropriately.

The Court found that no official with the VA "was able to provide the court with a sufficient justification for the delays in processing of Veterans' disability claims. ❖

10th Anniversary of World Trade Center Attack

On September 11, of this year, the United States and the world will pass a grim milestone: the 10th Anniversary of the largest and deadliest terrorist attack on United States soil.

Nearly three-thousand people perished on that Tuesday morning in attacks on the World Trade Center in New York, the Pentagon in Virginia, and a hijacked passenger plane which crashed in the Pennsylvania country-side while the passengers fought to avoid what they feared would be an attack on the Capital or the White House. People old enough to remember have little difficulty remembering exactly where they were and what they were doing when they heard that the world had changed forever.

Fortunately, no similar attack has occurred in the ten years since. But the world has indeed changed. The whole experience of air travel is different from pre-9/11. In a world of shoe-bombers, underwear bombers, and who-knows-what-next bombers, the leisurely and comparatively simple process of boarding a plane has turned into a grueling 90-minute gauntlet with removed shoes, belts, and other clothing articles.

And in the years since, numerous military personnel have faced peril, received grievous injury and trauma both physically and emotionally, in seeking to root out those who would revisit these attacks upon us. We healthcare providers of the VA work to care for them and to honor them, both living and dead. We must never forget. ❖

Inside this issue:

Samuel Spagnolo, MD

The President's Corner

In case you missed the news, the Federal Debt Limit has been raised and our government can now borrow an extra trillion for this coming year. The new update of an old saying is now "a trillion here and a trillion there and pretty soon you will have real money."

However, this was not great news to the government rating agencies with Standard and Poor's down-grading the long-term sovereign credit rating on the United States of America from 'AAA' to 'AA+' (http://www.standardandpoors.com/home/en/us). Other rating agencies are still threatening downgrades if the government does not demonstrate more seriousness about reducing the national debt.

After all the weeks of intense drama on Capitol Hill, there appear to be no real winners or losers except the American public. In case you haven't noticed, federal wages are frozen, the dollar continues to fall, interest on savings is nearly zero, prices for most consumer goods are rising, and your standard of living is falling.

Thus, having worked so hard, the Congress is now in recess for the next month. The recently signed "*Budget Control Act of 2011*" as it is officially called (http://www.gpo.gov/fdsys/pkg/BILLS-112s365eah/pdf/BILLS-112s365eah.pdf) consists of 74 pages of mostly complicated legal verbiage that few can completely understand. However, it appears there are no immediate cuts to federal pay or pensions. What may follow will be caps on spending in various agencies. It also appears that real government spending will increase by at least $900 billion. Reduction amounts for each agency are not specified in the new legislation. How much funding the Department of Veterans Affairs will have for the next several years remains to be seen but some agencies may have to resort to hiring freezes, furloughs and layoffs. We at **NAVAPD** will keep you informed of new development via the web site (www.navapd.org), email, and publications. ❖

NAVAPD's Mission and Principles

Mission

NAVAPD is dedicated to the principle that this Nation's Veterans, as a result of their service to our country's Armed Forces, have earned an entitlement to quality health care to meet their needs as they become sick or injured. The Department of Veterans Affairs ("VA") is that agency of government obligated to honor the Nation's contract with its deserved Veterans.

NAVAPD has as its highest priority the preservation and strengthening of the VA Health Care system, so that it stands ever ready to give Veterans quality medical care equal to or better than that which can be obtained elsewhere in our society.

Just as VA doctors care for those who have served, they also stand ready to treat the military and civilian casualties of future conflicts and non-military disasters.
VA Health Care facilities are a principal element in our national security and in our national defense, representing as they do a vast resource to back up the limited capabilities of our military hospitals.

Guiding Principles

NAVAPD shall function as the official professional organization of the VA physicians and dentists at all levels in the VA Health Care system, from the local health care facilities through VISNs to the national level.

NAVAPD shall cooperate to the maximum extent possible with official representatives of the VA, to the end that best possible health care is provided to Veteran beneficiaries.

NAVAPD shall endeavor to ensure that qualified physicians and dentists are recruited into the VA Health Care system and retained therein.

NAVAPD shall support VA physician research, participate in activities of professional organizations, continuing medical education and participation in equal partnership affiliation with medical schools.

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Summary of Major Provisions of Affordable Care Act

This is a summary of the major provisions of the enacted Health Reform Law, adapted from one provided by the AHA. The Law is intended to extend health coverage to 32 million people, 95 percent of legal residents and 92 percent of all U.S. residents. The Congressional Budget Office estimates that the legislation will cost $940 billion over 10 years.

Coverage Expansion, Individual Mandate, and Employer Responsibility: Expands access to coverage to 32 million individuals by 2019 through a combination of public program expansions and private section health insurance reforms. Beginning in January 1, 2014, all U.S. citizens and legal residents have to obtain coverage or face a tax penalty. Individuals with employer based coverage will be able to retain their coverage. Those without employer plans can obtain coverage through newly formed "health insurance exchanges." Subsides are available to assist low-income individuals with the purchase of health insurance premiums and Medicaid would be expanded to provide coverage for the poor. While employers are not required to provide coverage, large employers will be charged a "free rider" assessment if their employees purchase health care coverage through the exchange with federal premium subsidies.

Medicaid: Beginning in 2014, requires all state Medicaid programs to cover individuals up to 133 percent of the federal poverty level (FPL). States will receive federal funds to pay for the newly expanded populations starting with 100 percent federal financing for 2014-2017 and scaled down to 90 percent for 2020 and thereafter. States that have already covered this population will receive additional federal assistance.

Medicaid Disproportionate Share Hospital (DSH): Decreases Medicaid DSH payments by $14 billion with reductions beginning in fiscal year (FY) 2014. DSH reductions are not directly tied to increases in the level of insurance coverage; the final bill directs the Secretary to develop a methodology for reducing federal DSH allotments to all states in order to achieve mandated reductions. In making DSH reductions, the Secretary is instructed to look at a state's percentage of reduction in the uninsured, and whether a state targets DSH funds to hospitals with high Medicaid volumes or uncompensated care.

Medicare DSH: Decreases Medicare DSH by $22.1 billion beginning in FY 2014. The final bill would continue to reduce Medicare DSH payments by 75 percent to eliminate DSH payments that are above the "empirically justified" level, as determined by the Medicare Payment Advisory Commission. A portion of the 75 percent would then be returned to hospitals depending on the amount of uncompensated care they provide. This amount is subject to a trigger, and would be phased down if coverage increases.

Hospital Payment Updates: Reduces hospital Medicare payment updates by approximately $112.6 billion over 10 years. For 2010 (beginning April 1) and 2011, the hospital payment update would be reduced by 0.25 percentage point. Beginning in 2012, the market basket would be reduced by an estimate of productivity, *with added reductions* of 0.1 percentage point in 2012 and 2013, 0.3 percentage point in 2014, 0.2 percentage point in 2015 and 2016, and 0.75 percentage point in 2017, 2018 and 2019. In 2020 and beyond, hospital payment updates would be reduced by productivity. The final bill eliminates a provision in the Senate bill calling for the reductions not to occur if certain coverage targets are not met in 2014-2019.

Health Insurance Exchanges: Beginning in 2011, requires states to establish health insurance exchanges through which individuals and small businesses can purchase qualified private health insurance coverage. A Federal Employee Health Benefit Plan (FEBHP)-like, multi-state health insurance plan will be offered through the exchanges with oversight by the federal Office of Personnel Management. Consumer Operated and Oriented Plans (Co-OPS) will be created to foster non-profits, member-run health insurance cooperatives. There is no government-run program.

Health Insurance Reforms: Establishes, within 90 days of enactment, temporary mechanisms to provide coverage to individuals with pre-existing conditions and for non-Medicare eligible retirees over age 55. Within six months of enactment, it prohibits insurers from setting annual and lifetime limits, dropping coverage (except in cases of clear fraud), and excluding coverage to children based on a pre-existing condition. Also would allow parents to include dependent children up to age 26 on their health insurance. Beginning in 2014, health insurers would be prohibited from excluding coverage based on pre-existing conditions for adults, would have limits imposed on premium ratings, and must guarantee the issuance of coverage for anyone who seeks it.

Administrative Simplification: Provides for 11 specific expansions of the administrative simplification provisions under HIPAA by HHS, as well as periodic reviews (beginning Jan. 1, 2012 and every three years thereafter) of where greater uniformity would further improve operation of the health care system and reduce administrative costs. The process requires input from the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, the Health Information Technology Standards Committee, standard setting organizations, and stakeholders.

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Affordable Care Act Summary (continued)

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Bundling: Beginning in 2013, requires the Secretary to establish a national, voluntary, five-year pilot program on bundling payments to providers around 10 conditions. If successful, the Secretary may expand the pilots after 2015.

Readmissions: Beginning in FY 2013, imposes financial penalties on hospitals for so-called "excess" readmissions when compared to "expected" levels of readmissions based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for reporting program. Excludes critical access hospitals and post-acute care providers.

Accountable Care Organizations (ACOs): Beginning in 2012, allows hospitals, in cooperation with physicians, to provide leadership in voluntary ACOs, which would be responsible for managing the care of certain beneficiaries, and allows the Secretary to share some of the savings from improved care management with providers.

Value-Based Purchasing (VBP): Establishes a VBP program for hospital payments beginning in FY 2013 based on hospitals' performance in 2012 on measures that are part of the hospital quality reporting program. The program is budget neutral, with 1 percent of payments allocated to the program in FY 2013, growing over time to 2 percent in 2017 and beyond.

Hospital-Acquired Conditions (HACs): Beginning in FY 2015, adds a 1 percent penalty to hospitals in the top quartile of rates of HACs, resulting in reductions of $1.5 billion over 10 years.

Geographic Variation: Includes $400 million for payments for FYs 2011 and 2012 to section 1886(d) hospitals located in counties that rank in the lowest quartile for age, sex and race adjusted per enrollee spending for Medicare Parts A and B. The payments would be proportional to each hospital's share of the sum of Medicare inpatient PPS payments for all qualifying hospitals. Includes a commitment by the Secretary to commission two Institute of Medicine studies and convene a National Summit on geographic variation, cost, access and value in health care. One study will evaluate hospital and physician geographic adjustment factors, looking at their validity as well as the methodology and data used to create them. Allowable changes will be implemented by December of 2012. The second study will examine geographic variation in the volume and intensity of health care services and recommend ways to incorporate quality and value metrics into the Medicare reimbursement system. The Secretary will also convene a National Summit on Geographic Variation, Cost, Access and Value in Health Care later this year.

Innovation Center: Creates a Center for Medicare and Medicaid Innovation (CMI) within CMS by 2011 to test innovative payment and service delivery models that improve quality and reduce program expenditures within certain limited geographic areas.

Physician Self-Referral: Eliminates the exception for physician-owned hospitals under the Stark Law and grandfathers existing hospitals with a Medicare provider number as of December 31, 2010. It requires compliance with disclosure, patient safety, bona fide investment, and growth restriction rules. The bill also provides limited exceptions to the growth restrictions for grandfathered physician-owned hospitals including a new exception for hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

Physician Payment: The final bill does not address the physician payment issue. A short-term, temporary fix for the scheduled reduction in physician payment for the remainder of CY 2010 is currently being debated in separate legislation.

Primary Care Physicians: Requires states to increase Medicaid payment rates to primary care providers in 2013 and 2014 only to Medicare levels, and provides 100 percent federal funding for the incremental costs to states.

Independent Payment Advisory Board (IPAB): Creates a new, independent board that would make binding recommendations on Medicare payment policy and non-binding recommendations for changes in private payer payments to providers. The recommendations exclude providers such as hospitals (but not critical assess hospitals) through 2019.

340B Program: Extends eligibility for the 340B drug discount outpatient program to children's, cancer and critical access hospitals, as well as certain sole community hospitals and rural referral centers. It does not expand the program for existing 340B hospitals to cover inpatient drugs, and it exempts orphan drugs from required discounts for new 340B entities.

Graduate Medical Education: Contains no reductions in IME payments. Redistributes 65 percent of unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. Qualified hospitals would be able to request up to 75 new slots.

Long-Term Care Hospitals: Extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2008*. Would further delay full implementation of the 25% Rule, the short-stay outlier

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Affordable Care Act Summary (continued)

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cuts, and the one-time budget-neutrality adjustments planned by CMS. Extends current moratorium on new LTCH beds and facilities, with exceptions.

Rural Hospital Provisions: Sustains and improves access to care in rural areas through various improvements:
- Extends the outpatient hold-harmless payments for certain hospitals in rural areas
- Improves payments for low-volume hospitals
- Ensures that CAHs are paid 101 percent of costs for all outpatient services regardless of the billing methods elected
- Extends and expands the Rural Community Hospital Demonstration Program
- Extends the Medicare Dependent Hospital program for one year
- Extends the Medicare Rural Hospital Flexibility Program through 2012
- Extends reasonable cost reimbursement for laboratory services in small rural hospitals

Medicare Extenders: Includes one-year extensions of certain Medicare provisions, including Section 508 wage index reclassifications; increasing the work geographic index to 1.0; grandfathering direct billing for anatomic pathology technical component services; add-on payments for ground ambulance; outpatient therapy caps; and a 5 percent increase in physician payment for certain psychiatric therapeutic procedures.

Liability: Provides $50 million in appropriated funds for medical liability demonstrations.

Fraud and Abuse: The final bill contains significant additional funding to fight fraud and abuse, with increased financial penalties for existing policies as well as new requirements and penalties for providers, suppliers and others.

Excise Tax on High-Cost Health Plans: Creates an excise tax beginning 2018 for insurers of employer sponsored health plans and sets the threshold for the tax at $10,200 for individual coverage and $27,500 for family coverage.

Medical Device Tax: Beginning 2013, implements a 2.3 percent excise tax on medical device manufacturers. Exempts from the tax any device of a type that is generally purchased by the public, such as eyeglasses and hearing aids.

Other Revenue Provisions: Includes an assessment of $67 billion on health insurers beginning in 2014, and an assessment of $33 billion on brand-name pharmaceuticals beginning in 2011. ❖

Antipsychotics No More Effective than Placebo for PTSD

Drugs widely prescribed to treat severe PTSD symptoms for Veterans are no more effective than placebos and have serious side effects, including weight gain and fatigue. The surprising finding, from the largest study of its kind in Veterans, challenges current treatment standards so directly that it could alter practice soon.

Ten to 20 percent of those who see heavy combat develop lasting PTSD symptoms; about a fifth of those who get treatment receive a prescription for an antipsychotic medication, according to government numbers.

The new study, published in *The Journal of the American Medical Association*, focused on one medication, Risperdal. But experts said the results most likely extend to the entire class, including drugs like Seroquel, Geodon and Abilify.

The use of such drugs has grown sharply over the past decade. Thousands of returning troops found their PTSD symptoms did not respond to antidepressants, the only drugs backed by scientific evidence for the disorder. Doctors thus turned to antipsychotics, which strongly affect mood, to augment treatment, based almost entirely on their experience with them and expected effects.

To test those assumptions, researchers affiliated with the Veterans Affairs medical system added Risperdal to the treatment of 123 Veterans with the disorder. Some served in Vietnam, others in Iraq or Afghanistan; all had tried courses of antidepressant treatment with little relief.

After 6-months of treatment, these Veterans were doing no better than a similar group of 124 Veterans given a placebo. About 5 percent in both groups recovered, and 10 to 20 percent reported at least some improvement, using standardized measures.

The findings come at a time when the DoD VA are straining to provide treatment to returning service members who are not only concerned about the stigma of mental illness but are also often skeptical of the value of treatment. Surveys have found that only about half of those thought to need treatment actually seek it.

Studies suggest that talk therapy, alone with antidepressants, can accelerate relief of common symptoms, such as nightmares and reclusive behavior. These psychotherapies include relaxation skills; incrementally increased exposure to stress triggers; and challenging some inaccurate assumptions that fuel anxiety. ❖

Summary of the Budget Control Act of 2011

This is a quick and simple summary of the key aspects of the 74 page "Budget Control Act of 2011." That is the formal name of the compromise that resolved the Debt Ceiling crisis in early August.

An interesting and important aspect of the Act is that it treats VA funding as non-discretionary spending. This likely makes it more difficult for reduction of VA funding. However, since the VA is bundled in with the DoD, it might get included in automatic trigger cuts if the super committee doesn't achieve the cuts required.

Cutting Discretionary Spending:

- Reduces discretionary spending by $1.2 trillion over ten years (as compared to CBO's January adjusted baseline).
- Cuts next year's discretionary spending by $7 billion in budget authority (and $27 billion in outlays) below the level enacted in the final 2011 CR, for a total discretionary budget of $1,043 billion in budget authority.
- Keeps total discretionary spending below Fiscal Year 2011 levels for Fiscal Year 2013 by setting spending at $1,047 billion in budget authority.

Capping Discretionary Spending:

- Discretionary spending is capped each year for the next decade. If the spending caps are exceeded there is an across the board cut (known as a sequester) of discretionary spending (with a permissible exemption for military pay) to eliminate the excess spending.
- The discretionary caps are codified in law and can only be changed by enactment of future legislation.

Eliminating Waste Fraud and Abuse:

- The bill includes program integrity cap adjustments to ensure adequate funding of programs to reduce waste, fraud, and abuse in health care and SSI.
- These program integrity initiatives will generate additional savings in mandatory programs.
- Similar integrity adjustments were a successful in the 1997 Balanced Budget Agreement.

Emergency Spending Reform:

- Provides a definition of emergency spending that specifies that the spending must be for the prevention or response to the loss of life or property or a threat to national security that is unanticipated and temporary.
- Requires the President and Congress to concur on the designation of any spending as an emergency.
- For the first time, affirmatively provides Members of the House with the opportunity to offer an amendment during consideration of an appropriations bill to strike an emergency designation (thus subjecting the spending to the overall cap) and, if they wish, to offset the emergency spending with an across-the-board cut to other programs in the bill.

Joint Select Committee on Deficit Reduction:

- Creates a 12-member Committee tasked with developing recommendations to reduce the deficit by $1.8 Trillion over 10 years.
- The Speaker, House Minority Leader, Senate Majority Leader, and Senate Minority Leader will each appoint 3 members.
- The Committee is required to report by November 23, 2011.
- Each House is required to consider the Joint Committee's recommendations by December 23, 2011. In the Senate, the bill is not subject to filibuster.

Balanced Budget Amendment:

- Requires each Chamber to consider balanced budget amendments to the Constitution between October 1st and the end of the year.
- Should an Amendment achieve the necessary 2/3rds in either chamber, the remaining chamber would be required to consider that Amendment.

Pell Grant and Student Loan Reforms:

- Reduces mandatory spending on student loans by eliminating the interest subsidy for graduate studies (elimination of interest subsidies was part of the House-passed Balanced Budget Act of 1995, though it never became law) and eliminating the subsidies for on-time repayments. These provisions will save taxpayers approximately $22 billion.
- Redirects $17 billion in the student loan savings to reduce the Pell Grant shortfall for 2012 and 2013, helping maintain the maximum Pell Grant award for eligible students.
- Dedicates approximately $5 billion to deficit reduction.

Debt Limit Increase:

- Upon enactment of the cuts contained in this bill, the President can exercise authority to increase the debt limit by $900 billion (of which $400 billion is available immediately). This authority is subject to disapproval in Congress. If a disapproval is enacted, the $400 billion increase is paid for through an across the board spending cut.
- If the recommendations of the Joint Committee to reduce the deficit are enacted, the President may exercise authority to again increase the debt limit by up to $1.6 trillion. This authority is also subject to disapproval in Congress.
- In all cases, the debt limit increase is to be smaller than the total reduction in spending. ❖

Pass Along to a Colleague

Mail to: NAVAPD, P.O. Box 15418, Arlington, VA 22215

Join NOW!

Full-Time $160	Half-Time $100	Retired $80	Resident Fellow $45	LifeTime $1500

NAVAPD is the only national organization protecting the interests of VA physicians and dentists. Since 1975, NAVAPD has been your advocate and watchdog in Washington. **NAVAPD** will continue to focus on opportunities to improve pay and working conditions.

You can join by mail with this form

YES! I want to join NAVAPD! **3 ways to pay:**

☐ 1. Check (enclose) ☐ 2. Payroll Deduction $6.15/PP ☐ 3. PayPal (Renewal Only)

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☼☼☼New NAVAPD Phone Number **866-836-3520** New NAVAPD Phone Number ☼☼☼

NAVAPD President Meets with Virginia Lt. Governor

NAVAPD President Samuel Spagnolo recently attended an event hosted by Virginia Lt. Governor Bill Bolling (pictured at right with Dr. Spagnolo). While primarily a fundraising and promotional effort, the event allowed Dr. Spagnolo the opportunity to network and discuss issues regarding Veterans' health care with the varied community leaders, business leaders, and political operatives in attendance.

As anyone from the Washington, DC area can attest, one never knows which contact established at some gathering like this might prove critical when seeking to advance an issue or agenda through the political machinery. A casual introduction or conversation can open doors months later in a most valuable way. ❖

No Response from VHA Physician Pay Committee

In late January, NAVAPD submitted requested input to the VHA Management Steering Committee on Physician and Dentist Pay. Despite acknowledgement of receipt of the input and assurance that it would be considered by the committee, NAVAPD has received no follow-up from the Committee, despite NAVAPD requests.

NAVAPD was also told that it would "soon" be asked to suggest appointees to this Committee. Since the problems with the implementation of the Physician and Dentist Pay Law have long been a concern of NAVAPD, this was very promising news. Unfortunately, no such request for appointee suggestions has been received.

NAVAPD therefore continues to seek follow-up information on the work of the committee, proposed outcomes, and the opportunity to help populate this Committee that is so important to our members. We will keep you apprised of any correspondence and progress in this matter. ❖

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Reminder: New NAVAPD Telephone Number in Service

As reported in the last issue of the *NAVAPD News*, following a profound problem with the old telephone number in April, NAVAPD changed to a new provider of telephone service and launched a new, toll-free access number. You are urged to use this number when seeking to reach NAVAPD.

To be clear, the telephone service is an answering service. It is not located where the NAVAPD Officers or staff are located. NAVAPD operates a "virtual office," eliminating the ongoing expense of office space, office insurance, office staff, and office furnishings. This allows us to keep your memberships costs low.

Therefore, the individual who answers the call will not be able to connect you directly to the person you wish to speak with. Instead, you will leave a message with the operator who answers, and the appropriate individual will be in touch with you as soon as possible. We believe this will provide better service for you. ❖

Please Keep Address and Email Current with NAVAPD

Please notify NAVAPD of any changes in home or work address or your home e-mail address. One of the biggest benefits of membership is the information NAVAPD sends out. If we do not have your correct contact information, there is no way to assure that you receive this important correspondence. ❖

PLEASE RETURN YOUR 2011 NATIONAL SURVEY ON PATIENT CARE

NAVAPD recently mailed out a survey. This is a repeat of the survey of 2008. It is important that NAVAPD receive as many responses as possible to determine if there is any significant shift in physician perceptions of patient care in VA facilities.

Please return your completed survey as soon as possible.