Coalition for Whole Health
Recommendations on Coverage of Mental Health and Substance Use Disorder Services in the Essential Health Benefit Package

In 2010, Congress enacted the Affordable Care Act (ACA), which will substantially expand health insurance coverage for Americans, largely through state health insurance Exchanges for individuals and small businesses, and through an expansion of Medicaid for low-income individuals and families. ACA requires the plans in the Exchanges, as well as Medicaid expansion plans, to cover a set of "essential health benefits" that include "mental health and substance use disorder [MH/SUD] services, including behavioral health treatment." By including MH/SUD as essential services, Congress recognized that substance use disorders and mental illnesses are preventable, treatable health conditions, as accepted by the American Medical Association, all other public health and medical standards, and decades of scientific research.

A well designed Essential Health Benefits package that includes sufficient coverage for mental health and substance use disorders for children, youth and adults is central to efforts to ensure that health reform meets its potential to allow individuals and families to recover from these diseases, improve health, and bend the cost curve. The Coalition for Whole Health, a coalition of national organizations advocating for improved coverage for and access to mental health and substance use disorder prevention, treatment, rehabilitation, and recovery services, recommends full inclusion of mental health and substance use disorder services within the Essential Health Benefits framework. This includes incorporating MH/SUD services in each of the Essential Health Benefits categories, as appropriate, in addition to the *mental health and substance use disorder services* category per se.

The ACA creates broad health care service categories that must be covered by certain health plans. The ACA defines these Essential Health Benefits in ten general categories:

- mental health and substance use disorder services, including behavioral health treatment
- laboratory services
- emergency services
- hospitalization
- prescription drugs
- maternity and newborn care
- pediatric services
- rehabilitative and habilitative services and devices
- preventive and wellness services and chronic disease management
- ambulatory patient services

For an addiction and mental health system to be accessible, accountable, efficient, equitable and of high quality,[i] the Coalition for Whole Health ("the Coalition") believes that the Essential Health Benefits package covered by both qualified health plans operating in state Exchanges and by Medicaid expansion plans must include, at a minimum, the benefits detailed in this document. These recommendations are based on evidence based practices to sustain addiction and mental health recovery – regardless of the setting. A list of Coalition for Whole Health members who have endorsed this paper is attached.

Overview
Nearly one-third of adults and one-fifth of children had a diagnosable substance use or mental health problem in the last year.[ii] Individuals with severe addiction and co-occurring mental illness, a significant percentage of those with substance use or mental health problems, die prematurely--on average, 37 years sooner than Americans without severe addiction and mental health problems.[iii] A recent study found that people with serious mental illness die 25 years sooner than the general population from common medical conditions such as cancer and heart disease.[iv] Individuals with severe mental health and severe substance use disorders not only have greater mortality rates, but their health care costs throughout their lives are substantially higher, primarily due to preventable emergency department visits and hospital admissions and readmissions. Appropriate mental health and substance use disorder services will decrease costs in the medical system and lengthen the lifespan of millions of Americans with these illnesses. In 2007, the Agency for Healthcare Research and Quality found that nearly 13 percent, or one of every eight emergency department visits are related to a mental health or substance use disorder.[v] Several states have found that providing adequate mental health/addiction treatment

benefits stops the escalation in health care costs and reduces Medicaid spending. For example, Washington State found that one year after providing a full addiction treatment benefit, $398 per member per month savings were achieved in overall Medicaid spending.[vi] However, in 2009, 23.5 million Americans needed treatment for an illicit drug or alcohol problem, but only 4.3 million people received treatment – leaving a gap of 19.2 million Americans who needed treatment for a substance use disorder but did not receive it.[vii] In addition, only 4.1 million of the 9.8 million Americans who needed treatment for a serious mental illness received it.[viii]

The costs associated with untreated mental health/addictive disorders also affect private payers. In 2006, Robinson and Reiter estimated that more than two thirds of primary care visits are related to psycho-social reasons.[ix] Even after controlling for a number of chronic co-morbid diseases, depressed patients covered by private insurance had significantly higher costs than non-depressed patients across 11 chronic co-morbid diseases. The costs associated with alcohol or drug-related hospitals stays are staggering – an estimated $12 billion in 2006 alone. In addition, it has been shown that the children of drug or alcohol addicted people have higher medical expenses than children of non-addicted parents._Depression is one the of costliest health issues for U.S employers, estimated to cost $44 billion annually. Untreated alcohol and drug problems are the number one cause of disability claims and cause significant absenteeism and presenteeism. Total annual economic costs for untreated alcohol and drug abuse total approximately $327 billion.[x] This does not include the increased stress-related or trauma-caused medical costs for family members living with an active alcoholic or drug abusing person.

When substance use and mental health conditions are addressed and treated as the preventable, treatable chronic diseases they are, systems reap substantial cost savings while dramatically improving health. Inclusion of prevention, treatment and recovery of mental illness and substance use disorders through the ACA's Essential Health Benefits package will reduce health costs and ensure that millions of people lead healthier lives, thereby strengthening individuals, families, communities, and our nation as a whole.

The Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and Additional Provisions to Ensure Good Access to Care

With passage in 2008 of the federal "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act" (MHPAEA), Congress sought to end the long history of insurance discrimination against those with MH/SUD that has prevented so many individuals from receiving the clinically appropriate type, level and amount of care needed to get and stay well. MHPAEA precludes group health plans from providing MH/SUD benefits in a more restrictive way than other medical and surgical benefits. The Affordable Care Act extends MHPAEA's requirements to qualified health plans in the state-based health insurance Exchanges and Medicaid benchmark coverage offered under the Medicaid expansion. Plans may use cost containment techniques but must manage MH/SUD benefits comparably with the way they manage other medical conditions. Final MHPAEA regulations implementing parity in Medicaid managed care plans and clarifying what plans' scope of services are, and what their non-quantitative treatment limitations obligations are, must be fully implemented. To ensure that the MH/SUD provisions of the ACA are implemented well, MHPAEA must first be fully implemented. A fully operationalized MHPAEA must serve as the fundamental building block on which the MH/SUD essential health benefit provisions in the Affordable Care Act are built. Without this non-discriminatory "floor," meaningful access to MH/SUD benefits will not be achieved.

As the Essential Health Benefits package is implemented, the Coalition also believes it must be affirmed that State laws which provide better coverage, rights, methods of access to health care services and consumer protections from the standpoint of the insured are not preempted by the Affordable Care Act. This is consistent with Section 1321(d) in the ACA that makes clear that State laws will not be superseded by the new federal law.

We also support the other consumer protections in the law intended to ensure comprehensive access for covered individuals to all essential services outlined in the Essential Health Benefits package. In particular, we strongly support the requirement in the law that the Secretary shall "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life."[xi] These protections have very significant implications for individuals with mental health and/or substance use disorders and health and mental health consequences for their family members, and we ask that enforcement of these protections be included among the highest priorities for implementation and ongoing administration of essential health coverage and other health plan requirements.

Proposed Components of Comprehensive Coverage of MH/SUD in the Essential Health Benefits Package

The recommended MH/SUD benefits delineated below are based in part on a review of existing employer plans, because the ACA requires the essential health package to reflect those covered in a "typical employer plan." At the same time, however, because final MHPAEA regulations have not been issued, and enforcement of existing regulations has been limited, the parity-based services required under ACA are not yet reflected in the current insurance market. Therefore, this list also draws on evidence-based and best practice approaches to habilitative and rehabilitative services for individuals and families who have MH/SUD as well as employer surveys done by the National Business Group on Health and the Kaiser Family Foundation.[xii,xiii] Like for other chronic illnesses, the Coalition recommends an array of services to meet the needs of plan participants at all stages of the continuum of their MH/SUDs, from mild to severe impairment. Clearly, some services will be necessary for only the severely mentally ill and addicted, while other services will meet the needs of those with mild to moderate MH/SUD.

Under the ACA, MH/SUD treatment must be sufficient to provide medically necessary care. Plans must be required to provide transparent definitions of medical necessity for mental health, substance use disorder and other medical conditions so that parity compliance can be measured. To date, the National Quality Forum has developed the most comprehensive quality standards for treatment of SUD.[xiv] Based on these extensively researched standards and others, the following represents the specific components of comprehensive MH/SUD coverage, which can be delivered in a range of settings, that the Coalition for Whole Health recommends be required as essential health benefits:

Mental Health and Substance Use Disorders, Including Behavioral Health Treatment

Assessment: For those assessed as needing MH/SUD services, individualized assessment tools must drive the quality of care. Targeted MH/SUD services must be included in a distinct treatment plan and the beneficiary must be involved in the treatment planning process. The Coalition for Whole Health supports provisions that require the use of standardized assessment tools under the ACA. Standardized screening and assessment tools, such as the Patient Health Questionnaire for one example, will allow clinicians to identify symptoms and problems and determine the specific interventions that will best treat an individual's presenting symptoms. Standardized assessment tools should include:

- Assessment of health including a comprehensive bio-psychosocial assessment of related mental health and substance use issues, and of needs and strengths that can be used to help individuals attain their treatment, other service and support goals
- Ongoing mental health and substance use disorder assessments using evidence-based assessment tools
- Specialized evaluations including psychological and neurological testing
- Diagnostic assessments of MH/SUD in general medical settings, including education and counseling for mild MH/SUD

Patient Placement Criteria: Today, evidence-based patient placement criteria can help to effectively place individuals into the optimal level of MH/SUD care for the amount of time that is deemed medically necessary. For example, the *Patient Placement Criteria for the Treatment of Substance-Related Disorders-- Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a widely used tool by which practical and clinical determination of substance use levels of care can be measured; ASAM criteria are currently used in some form in 30 states and have been adopted by a wide range of commercial payers and providers.[xv] Similar mental health patient placement tools exist, such as Locus. In addition, the Substance Abuse and Mental Health Services Administration is working with ASAM to develop the Recovery Support Services Assessment Tool which will be a useful tool in assessing recovery support needs. More work is needed to further develop these tools for operational use. Where available, patient placement criteria should be used for the placement of patients in the appropriate level of care. As a result of MHPAEA and ACA, medically necessary care cannot be subject to annual or lifetime benefit caps, nor can there be arbitrary limits on MH/SUD that are not imposed on other medical conditions. The effects of MH/SUD treatment are optimized when patients receive ongoing recovery supports and information on managing their own illness, and best outcomes occur when individual patients are matched with appropriate levels of care.[xvi]

Outpatient Treatment: As the parity provisions of the ACA require, outpatient treatment services are to be provided as long as medically necessary with no limits on duration or frequency and patients must be allowed to access treatment to manage relapses, as is the case with other chronic conditions. The totality of substantiated interventions that offer promise for treatment resistant cases must also be covered in the essential health benefit package. Outpatient treatment services should include evidence-based:

- Individual, group, and family therapies
- Devices and technology interventions for mental health and addictive disorders
- General and specialized outpatient medical services
- Consultation to caregivers and other involved collateral contacts, such as school teachers, in accordance with confidentiality requirements
- Evidence-based complementary medicine services, comparable to complementary medicine services covered for other health conditions[xvii]
- Monitoring services, comparable to those provided to determine compliance with the treatment regimens for other health conditions

Intensive Outpatient Services: Intensive outpatient and partial hospital programs are ambulatory time-limited treatment programs which offer therapeutically intensive, coordinated, and structured group-oriented clinical services as either a step down or alternative to inpatient acute services for both MH and SUD populations. These services stabilize acute crises and clinical conditions, utilizing recovery principles to help return individuals to less intensive outpatient, case management, peer support, and /or other recovery based services. Coverage of these services is an integral part of most private MH/SUD benefit packages.

Intensive outpatient covered benefits should include:

- Substance use intensive outpatient treatment
- Mental health intensive outpatient treatment
- Partial hospitalization
- Dual-diagnosis partial hospitalization and intensive outpatient services for persons with co-occurring MH and SUD conditions
- Intensive case management for MH/SUD

Residential Services: Residential MH/SUD services are a key component of an optimally-functioning service delivery continuum and help offset the costs associated with emergency department visits, hospital admissions and readmissions.[xviii] In 2008, approximately 2 million adults received inpatient or residential care for mental health problems.[xix] According to SAMHSA's 2009 National Survey of Substance Abuse Treatment Services (N-SSATS), as of 2009, 13,513 substance abuse treatment facilities provided medication, counseling, behavioral therapy, case management, and other types of services to persons with substance use disorders. Of these 13,513 facilities, 4,317 provided inpatient services. Of the 4,317 facilities providing inpatient services, 3,520 or 81.5% were non-hospital residential treatment facilities, and merely 797 or 18.5% were hospital-based treatment providers. The National Survey shows that during 2009, of the 117,515 individuals who obtained inpatient substance abuse treatment, 103,174 or 87.8% received inpatient treatment in a residential, non-hospital facility, and merely 14,341 or 12.2% received inpatient treatment in a hospital setting.[xx]

Coverage of medical residential services is also common in most heath plans. Milliman, Inc found that most health plans have analogous levels of care with MH/SUD residential services including orthopedic, stroke and cardiac rehabilitative services in non-hospital settings.[xxi]

Placement in a residential or inpatient setting—as with placement at all levels of MH and SUD care across the continuum—should be based on the individual needs of the patient. Patients should be regularly assessed to ensure that they are at all times placed within the appropriate treatment setting for the appropriate duration, receiving the appropriate level of care befitting their needs and the severity of their illness. To the greatest extent possible the use of uniform patient placement criteria should drive placement decisions.

Residential treatment is an essential part of this treatment continuum. ASAM and other professional organizations define residential treatment as occurring 24 hours a day, in a live-in setting that is either housed in or affiliated with a permanent facility. While there are several types of residential programs of varying intensity, a defining characteristic of all residential programs is that they serve "individuals who require safe and stable living environments in order to develop their recovery skills." The services provided are organized and staffed by addiction and mental health personnel who provide a planned regimen of care, and generally include medical and social services needed by the patient population. Analogous residential treatment modalities for other medical conditions include stroke rehabilitation, spinal cord injury rehabilitation, traumatic brain injury rehabilitation, and orthopedic rehabilitation.[xxii] Covered benefits should include:

- Residential crisis stabilization
- Detoxification in clinically-managed non-hospital residential treatment facilities for SUD care, including the use of medication-assisted withdrawal management services
- Mental health residential for adults and youth
- Substance use disorder residential, including the use of medication-assisted treatment, for adults and youth[xxiii]
- Dual-diagnosis residential services for adults and youth with co-occurring MH and SUD conditions
- Clinically managed 24-hour care
- Clinically managed medium intensity care
- Inpatient psychiatric hospital
- Inpatient mental health and substance use disorder care
- Inpatient hospital dual-diagnosis care for youth and adults with co-occurring MH and SUD conditions

Laboratory Services

While the use of laboratory tests at all levels of care (hospital, residential, outpatient) is clearly indicated to identify potentially co-occurring general medical conditions, or general medical complications of treatments for MH/SUD conditions, evidence-based medical care for persons with MH/SUD conditions requires the ability to offer integrated general medical and MH/SUD care. The Essential Health Benefit should include coverage for laboratory tests whether offered by MH/SUD specialists, general medical professionals such as primary care providers, or persons in non-behavioral, non-primary care medical/surgical specialties.

- Laboratory services, including drug testing

Emergency Services

- Crisis services in both MH/SUD and medical settings, including 24 hour crisis stabilization and mobile crisis services, including those provided by peers
- 24/7 crisis warm and hotline services
- Hospital-based detoxification services

Prescription Drugs

Pharmacotherapy and Medication-Assisted Treatment: Medications approved for mental illness, alcohol, drug and tobacco treatment are proven to be effective and must be a covered essential health benefit. All FDA approved medications should be covered for SUDs and matched to the assessed individuals' clinical need and personal preference. The full continuum of FDA approved medications for MH/SUD must be covered and parity in access to medications prescribed for the treatment of mental health and substance use disorders must be enforced. Coverage should be continued as long as medically necessary with no limits. Medication services should include:

- Medication management
- Medication administration
- Pharmacotherapy (including medication-assisted treatment)
- Home-based, mobile device or internet-based medication adherence services
- Assessment for medication side effects
- Appropriate wellness regimens for consumers who are experiencing metabolic effects as a result of their medication

Rehabilitative and Habilitative Services and Devices

The history of insurance discrimination in MH/SUD benefits has been a major barrier for individuals to access the type and amount of care they need. Individuals with histories of untreated chronic conditions, including MH/SUD, may have complex and varied health problems that will need to be addressed to help them to get and stay well.

Case management has been identified by both medical and behavioral health authorities as an effective service for improving health outcomes among people with chronic medical, mental health and substance use disorder conditions.[xxiv] Comprehensive case management secures access to and retention in services, promoting compliance with recommended treatment protocols throughout an episode of care. For patients with severe substance use and mental health conditions, multiple co-morbidities and for patients who are resistant to medically necessary treatment, case management services are necessary to promote participation in treatment of sufficient intensity and duration to address underlying illness. Case management also supports successful transitions between more structured care (i.e., residential, partial hospitalization, detoxification services) and less structured care (i.e., outpatient) and addresses practical barriers to participation that impede clinical progress. These effective strategies to improve health outcomes through care management and coordination are consistent with those in the ACA that seek to reduce costs and improve chronic disease care.

Rehabilitative Services: The following rehabilitative services should be covered:

- Psychiatric rehabilitation services
- Behavioral management
- Comprehensive case management in physical health or MH/SUD settings which should include individualized service planning with periodic review to address changing needs, treatment matching, navigation between all needed services, communication between all service providers, enrollment in Medicaid/insurance, and support to maintain continued eligibility
- Assertive Community Treatment (ACT) Teams
- Peer provided telephonic and internet based recovery support services, including those delivered by recovery community centers
- Recovery supports, including those delivered by peer run mental health organizations
- Skills development including supported employment services

Recovery supports: Twenty-three states provide Medicaid reimbursement for peer-delivered mental health and/or addiction recovery support services.[xxv] Ongoing recovery supports for at least one year following an active phase of treatment have treatment has been shown to improve and sustain treatment and health outcomes for individuals with substance use disorders.[xxvi] Recovery supports have also been shown to be an effective engagement tool prior to and during treatment. A June 2008 study of Texas drug court participants who received recovery support services found that “among the specific types of recovery support services, those that were most closely related to the process of recovery such as individual recovery coaching, recovery support group, relapse prevention group and spiritual support group, were more strongly associated with successful outcomes.”[xxvii]

For other individuals, recovery supports are their preferred method of self-managing addiction and mental health issues. Recovery support coaching (both clinical and non-clinical) serves as a strengths-based method for individuals to achieve health and wellness goals. Telephonic recovery support services (provided through recovery support centers) have been shown to improve health outcomes and sustain recovery one year following treatment.[xxviii] Certain interactive communication technology devices should be covered if the interactive device aids in sustaining a beneficiary's recovery. Recovery support services should include:

- Peer provided recovery support services for addiction and mental health conditions
- Recovery and wellness coaching
- Recovery community support center services
- Support services for self-directed care
- Community Support Programs and other continuing care for mental health and substance use disorders

Habilitative Services should include**:**

- Personal care services
- Respite care services for caregivers
- Transportation to health services
- Education and counseling on the use of interactive communication technology devices

Preventive and Wellness Services and Chronic Disease Management

According to National Institute of Mental Health research, 50 percent of all lifetime mental health and substance use disorders start by age 14. Yet, because the early signs of a mental health disorder or substance use disorder often are missed, diagnosis regularly occurs 10 years or more after the onset of symptoms and the disease is then allowed to progress. In addition, children who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs as adults than those who first use marijuana at age 18.3.[xxix] Furthermore, adolescents who begin drinking before the age of 15 are four times more likely to develop alcohol dependence, whereas each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14%.[xxx] It is therefore critical that health-related school, community wide and workplace health promotion initiatives include a specific and discrete emphasis on substance use/abuse prevention and mental health promotion.

The ACA places a mandatory requirement on all group health plans and health insurance issuers offering group or individual health insurance to offer, without cost-sharing, a minimum level of preventive health services, including services that have a rating of A or B by the United States Preventive Services Task Force (USPSTF). These mandatory USPSTF recommendations include depression screening for adults and youth age 12 to 18, alcohol screening and counseling and tobacco screening and cessation interventions for adults. These and other preventive services, such as drug screening and counseling, are a critical component of prevention and should be included in the preventive and wellness services and chronic disease management Essential Health Benefit because approximately four million Americans have both a serious mental illness and a substance use disorder.[xxxi] Health promotion is also a significant part of comprehensive prevention and wellness plans and should be included in the preventive and wellness services and chronic disease management Essential Health Benefit. Services identified in the Preventive, Wellness and Chronic Disease Management Essential Health Benefits category should include:

- Screening (including screening for depression, alcohol, drugs, and tobacco), brief interventions (including motivational interviewing) and facilitated referrals to treatment
- General health screenings, tests and immunizations
- Appropriate MH/SUD related educational programs for consumers, families and caretakers, including programs related to tobacco cessation, the impact of alcohol and drug problems, depression and anxiety symptoms and management, and stress management and reduction, and referral for counseling or support as needed

- Caretaker education and support services, including non-clinical peer-based services, that engage, educate and offer support to individuals, their family members, and caregivers to gain access to needed services and navigate the system
- Health coaching, including peer specialist services, provided in person or through telehealth, e-mail, telephonic, or other appropriate communication methods
- Health promotion, including substance use prevention and services that impact well-being and health-related quality of life
- Wellness programming for youth, including student assistance programming
- Services for children, including therapeutic foster care
- Interventions aimed at facilitating compliance with treatment and improving management of physical health conditions
- Care coordination (including linkages to other systems, recovery check-ups, linkages to peer specialists, recovery coaches, or support services based on self-directed care)
- Relapse prevention, including non-clinical peer-based services, to prevent future symptoms of and promote recovery strategies for mental and substance use disorders.

For these preventive services to have the greatest impact on community health and health care cost efficiencies, beneficiaries should receive substance use and mental health screenings free of cost sharing; even if they visit a health professional for another service. Under interim final ACA regulations, beneficiaries must make an appointment specifically for preventive care in order for the screenings to be free of cost sharing. However, with SUD and MH screenings in particular, it is critically important that no-cost screenings be allowed during visits for other primary care services, since individuals most in need of mental health and addiction screenings are unlikely to seek them out on their own.

Screening, Brief Intervention, and Referral to Treatment, or SBIRT, is a preventive intervention that has been shown to be very effective in hospitals, health clinics and primary care settings in reducing MH/SUD prevalence and future emergency room visits.[xxxii] SBIRT targets people who are just beginning to be symptomatic with mental health or substance use disorders (including tobacco). Medical benefits must support and encourage SBIRT through full reimbursement in emergency rooms and primary care settings. Laws and policies that create barriers to screening, including state Uniform Policy Provision Laws (UPPL) that permit insurers to deny reimbursement for any injury that occurs while a patient is under the influence of alcohol or other drugs, must be repealed or preempted.[xxxiii]

Coverage for Youth

While most services mentioned above apply to youth, there are additional MH and SUD services that are only appropriate for youth and families. These services are listed below in the appropriate corresponding Essential Health Benefits categories.

The Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit should serve as a model for coverage for children and youth up to age 21 who are insured through the state Exchanges and Medicaid expansion plans.[xxxiv] These comprehensive benefits are essential to ensure the early identification, treatment and recovery of youth diagnosed with a mental illness or substance use disorder. Specific attention should also be paid to ensure that the needs of transition age youth are well met.

Maternal and Newborn Services

- Pre-natal and peri-natal screening and brief interventions for maternal depression and substance use disorders and referral to treatment
- Health education
- Targeted case management

- Maternal, infant, and early childhood home visiting programs

Pediatric Services

- Screening for substance use, suicide, and other mental health problems using tools such as the CAGE questions, the Alcohol Use Disorders Identification Test (AUDIT) instrument and other rapid identification tools[xxxv,xxxvi]
- Early intervention services
- Service planning
- Caretaker coaching on children's social/emotional development and support
- Therapeutic mentoring
- Skill building
- Intensive home-based treatment
- Targeted case management

Conclusion

The Affordable Care Act holds tremendous promise for the millions of Americans with, at risk for, or in recovery from mental health and substance use disorders. Providing the full range of MH and SUD prevention, treatment, recovery and rehabilitation across the lifespan will save lives, improve health, and reduce health costs. We appreciate your consideration of the above recommendations and ask that you use us as a resource moving forward.

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