Nos. 19-2210, 20-2024

IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

New Mexico Oncology and Hematology Consultants, Ltd.,

Plaintiff-Appellant/Cross-Appellee,

v.

Presbyterian Healthcare Services, Presbyterian Network, Inc., Presbyterian Health Plan, Inc., and Presbyterian Insurance Co., Inc.,

Defendants-Appellees/Cross-Appellants.

On Appeal from the United States District Court
for the District of New Mexico (Case No. 1:12-cv-00526)
The Honorable Martha Vazquez, District Judge

BRIEF OF *AMICUS CURIAE* AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFF-APPELLANT/CROSS-APPELLEE AND IN SUPPORT OF REVERSAL

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DISCLOSURE OF CORPORATE AFFILIATIONS

Pursuant to FRAP 26.1, the American Medical Association hereby discloses that it has no parent corporation and that no corporation holds 10% or more of an ownership interest in it.

July 6, 2020

s/ Leonard A. Nelson
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INTEREST OF *AMICUS CURIAE*

Amicus curiae, the American Medical Association ("AMA"), submits this brief in support of Plaintiff-Appellant/Cross-Appellee New Mexico Oncology and Hematology Consultants, Ltd. ("NMOHC"), and in favor of reversal of the district court's grant of summary judgment on NMOHC's antitrust claims.[1]

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state, including New Mexico.

The AMA submits this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical

[1] *Amicus curiae* hereby certifies that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund preparation or submission of this brief, and no person other than *amicus* and its counsel contributed money intended to fund preparation or submission of the brief. Because the parties did not consent to the filing of this brief, *amicus curiae* has concurrently filed a motion for leave to submit this brief.

societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

The AMA has an interest in ensuring that physicians can deliver quality, affordable care to its members' patients, and it is committed to challenging anticompetitive rules and procedures that are antithetical to patient care, such as those adopted by Defendants-Appellees/Cross-Appellants (collectively, "Presbyterian"). The AMA submits this brief to address the critical role of medical ethics in this case, and the impact that the district court's decision could have on anticompetitive practices if allowed to stand. Robust enforcement of antitrust law by physician groups, like NMOHC, is critical to protecting patients from the harm of anticompetitive practices by entities that have accumulated a dominant market share. *Amicus curiae* respectfully submits that the district court's grant of summary judgment should be reversed and the case remanded for further proceedings.

SUMMARY OF ARGUMENT

Medicine is complex and beyond the expertise of the average person. This is not a case about ski lift passes, computer software, or newspaper advertisements, but rather, the prevention, diagnosis, and treatment of serious health issues, including leukemia and other forms of cancer. It is through the lens of medical practice and ethics that NMOHC's antitrust claims must be evaluated and Presbyterian's actions judged. *See Verizon Communications Inc. v. Law Offices of Curtis V. Trinko*, *LLP*,

540 U.S. 398, 411 (2004) ("Antitrust analysis must always be attuned to the particular structure and circumstances of the industry at issue").

The district court, however, failed to properly consider the nature of the health care industry and the harm that Presbyterian's conduct had on the "consumers," namely patients dealing with the effects of possibly life-threatening health issues. Particularly vital is the information physicians give patients, as "[T]he physician [has] the responsibility of satisfying the vital informational needs of the patient." *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972). Unfortunately, the information asymmetries that exist between physicians and patients highlight the need for more, not less, disclosure to patients. "A lack of good information . . . hampers consumers' ability to evaluate the quality of the healthcare they receive." *See, e.g.*, Department of Justice and Federal Trade Commission, *Improving Health Care: A Dose of Competition* at 5 (July 2004) (hereinafter, *Improving Health Care*).[2]

Competition in health care markets has generally suffered from information failure, and unfortunately:

> The public has access to better information about the price and quality of automobiles than it does about most health care services. It is difficult to get good information about the price and quality of health care goods and services . . . Without good information, consumers have

[2] *Available at* https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

> more difficulty identifying and obtaining the goods and services they desire.

Id. at 6.

ARGUMENT

I. Health care providers, including physicians and nurses, have an ethical duty to their patients that must be considered in the judicial review of health care-related antitrust claims.

The duty of physicians to provide the best medical care to their patients is paramount. *See* AMA, Preamble, AMA Principles of Medical Ethics ("As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.").[3] Physicians are ethically obligated to provide the best practicable medical care to their patients. *See* AMA, Code of Medical Ethics Opinion 1.1.6.[4] In fact, the practice of medicine "is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering." AMA, Code of Medical Ethics Opinion 1.1.1.[5] The relationship between a patient and a physician:

> is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

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[3] *Available at* https://www.ama-assn.org/delivering-care/ama-principles-medical-ethics.

[4] *Available at* https://www.ama-assn.org/delivering-care/quality.

[5] *Available at* https://www.ama-assn.org/delivering-care/patient-physician-relationships.

Id. Accordingly, physicians must make certain that they are not restricted in ways that materially compromise their primary duty: to ensure that the patient is provided with quality medical care.

The relevant standard for nurses is much the same. *See* Code of Ethics for Nurses with Interpretative Statements of the American Nurses Association ("ANA"), Provision 2 ("The nurse's primary commitment is to the patient").[6] Likewise, Section 1.4, *The Right to Self-Determination* of the ANA Code of Ethics states that patients also have the right to "accept . . . treatment without . . . undue influence [or] duress." *Id.*

Providing quality care at the lowest cost has become more difficult in recent years as hospitals, health insurers, and physician services have consolidated at increasing rates. *See* Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, Health Affairs 36:9, 1530-38 (2017).[7] Although hospitals and insurance companies often argue that provider concentration should benefit patients, the evidence does not support that contention. *Id*. at 1531. In fact, "reviews of studies of hospital markets have found that concentrated markets are associated with higher hospital prices," and in some cases,

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[6] *Available at* https://www.princetonhcs.org/-/media/princeton/documentrepository/documentrepository/nurses/code-of-ethics.pdf.

[7] *Available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0556.

"higher mortality rates." *Id.*; *see also* Robert A. Berenson, *A Physician's Perspective on Vertical Integration*, Health Affairs 36:9, 1586 (2017) ("Whatever the theoretical arguments, empirically it is becoming increasingly clear that vertical integration typically leads to higher prices and costs and does not improve quality.").[8]

Presbyterian, the dominant market power in Albuquerque in both the provision of health care and the provision of health care insurance, was committed to further expanding its reach by either acquiring NMOHC or crippling its ability to continue serving patients. *See* Dkt. 848 at 22-26 (discussing the history between NMOHC and Presbyterian). In doing so, however, Presbyterian took actions that harmed patient welfare. NMOHC was and remains acutely aware of its duty to its patients, and its complaint in this case is replete with allegations regarding the harm that would and did occur to patients if it was forced to limit its services or close its doors. Were this to happen, cancer patients in the Albuquerque area would receive lower quality care while paying more for that care. *See, e.g.*, Dkt. 123 at ¶¶ 6, 116, 152, 243-247.[9]

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[8] *Available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0848.

[9] The AMA refers to the allegations in the Complaint because a significant portion of the record is sealed in this case. *Amicus curiae* respectfully submits that if this case is remanded, this Court should order that the sealed documents be reevaluated in favor of public access, especially to the extent that documents and testimony implicate the quality of and access to health care as a result of Presbyterian's conduct. *See, e.g.*, *JetAway Aviation, LLC v. Board of County Com'rs of County of Montrose, Colo.*, 754 F.3d 824, 826-27 (10th Cir. 2014) (denying motion to seal purported confidential documents).

In order to properly evaluate this case and NMOHC's claims, this Court "must be . . . attuned to the particular structure and circumstances of the" health care field. *See In re: Cox Enterprises, Inc.*, 871 F.3d 1093, 1103 (10th Cir. 2017). Medical ethics and the delivery of quality, affordable care are critical in that analysis, and *amicus curiae* respectfully submits that the district court failed to consider those issues in granting Presbyterian's motion for summary judgment.

II. Presbyterian acted willfully to extend its monopoly power, thus violating Section 2 of the Sherman Act.

The seminal case on Sherman Act § 2 is *United States v. Grinnell Corp*., 384 U.S. 563 (1966), which held that this statute violated if the defendant possesses monopoly power *and* obtained or maintains that power through "willful" conduct. On this appeal, Presbyterian's possession of monopoly power is not in dispute, as the trial court held that "the Court well might conclude that a genuine issue of fact remains as to [Presbyterian's] possession of monopoly power." Dkt. 848 at 19. Thus, the important question on appeal is whether the facts, when viewed through the lens of a summary judgment motion, create an issue of fact as to whether Presbyterian engaged in *willful* conduct, as contemplated in *Grinnell*.

The Supreme Court has never defined exactly when conduct should be deemed willful. According to the leading antitrust law treatise, though, in this context willful conduct must be in some measure illicit. *See* Areeda & Hovenkamp, *Antitrust Law*, § 615b (4th ed. 2015). Further considerations of willfulness depend

on whether the conduct at issue impairs the ability of rivals to compete, beyond the impairments which would be justified by superior business acumen or efficiency. *Id.* at § 650. This, in turn, may depend on whether the monopolist's behavior harms consumers more than it benefits them. *Id.* at § 651a. A critical consideration is whether the allegedly willful conduct is such that it could affect an actual or potential rival's choice of whether to enter a market or expand a business. *Id.* at § 651g. If a firm has been "attempting to exclude rivals on some basis other than efficiency, it is fair to characterize its behavior as predatory," and accordingly, it is "appropriate to examine the effects of the challenged pattern of conduct on consumers." *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 (1985).

In fact, the "proper focus of section 2 isn't on protecting competitors but on protecting the process of competition, with the interests of consumers, not competitors, in mind." *Novell, Inc. v. Microsoft Corp.*, 731 F.3d 1064, 1072 (10th Cir. 2013); *see also* David M. Cutler and Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, Journal of American Medical Association, Vol. 310, No. 18, 1968-69 (Nov. 13, 2013) ("The sole question for antitrust agencies in considering whether health systems would become too large with a particular consolidation is whether consumers will be better or worse off as a result. The financial status of any health care organization is immaterial, except insofar as it affects consumer

welfare.").[10] In this case, Presbyterian's actions should be deemed willful, at least for purposes of summary judgment.

A. Presbyterian forced patients to receive their oncology drugs from Presbyterian when, for compelling clinical reasons, patients would have preferred to receive them from NMOHC.

Presbyterian, through the Mandate, harms patients to advance its monopoly power. *See* Dkt. 123 at ¶¶ 303-439 (describing the mandate in detail); Dkt. 848 at 40-46. The Mandate is a program designed by Presbyterian that dramatically alters how NMOHC patients who are enrolled in the Medicare Advantage program can receive their medications. *See* Dkt. 848 at 40. For years prior to the implementation of the Mandate in 2012, NMOHC dispensed medication for its patients in-house through its own pharmacy. *Id.* at 42. This created significant benefits, not only to NMOHC, but more importantly, to NMOHC's patients. Dkt. 123 at ¶¶ 317-330. Chemotherapy drugs and other support medication to help treat cancer are complex, and they require special handling to ensure that they retain their potency and efficacy. *Id.* at ¶ 317. Moreover, the timing for administering the medication is of critical importance and failing to take medication on time can reduce the overall effectiveness of the patient's treatment program. *Id.* at ¶¶ 319-323; *see* Kathryn S. Burnett, *White-Bagging vs. Buy-and-Bill: Practical Considerations for Physicians Administering Specialty Pharmaceuticals*, 8 J. Health & Life Sci. L. 42 at 63 (June

[10] *Available at* https://jamanetwork.com/journals/jama/fullarticle/1769891.

2015).[11] Failing to receive prescribed medication at the proper time can lead to serious infections and even death. Dkt. 123 at ¶ 322.

The physician-owned treatment settings, such as NMOHC, dispense and administer drugs where patient compliance with dosing amounts and intervals can be monitored, side effects evaluated, and, if necessary, critical drug dosages adjusted. These are clinical services that patients receiving specialty drugs often need to stay alive. Critically for NMOHC, if it accepted deliveries of medications from Presbyterian's specialty pharmacy, it would be unable to verify where the medications were purchased or how they were handled before arriving at NMOHC. Dkt. 848 at 43; *see also* American Society of Clinical Oncology, *Pharmacy Benefit Managers and Their Impact on Cancer Care* 5, 9-10 (Sept. 6, 2018) (discussing the negative impact on patient care when cancer medications are shipped from pharmacies to treating provider).[12]

NMOHC refused to compromise its medical ethics and risk patient care for its bottom line, exactly as Presbyterian had hoped. *See* Dkt. 848 at 43. The implementation of the mandate: (1) created a windfall for Presbyterian of millions of dollars per year, which it had unsuccessfully been trying to extract from NMOHC

[11] *Available at* https://www.cwlaw.com/assets/htmldocuments/KBUR-Journal-June2015-practice-resource1.pdf.

[12] *Available at* https://www.ncoda.org/wp-content/uploads/2018/09/ASCO-Position-Statement-PBMs-Aug.-2018.pdf

in other areas; (2) pulled profits from NMOHC; and (3) most critically for this case, it harmed patients. As the district court noted, but failed to fully appreciate in its antitrust analysis, several NMOHC patients complained about the Mandate, "reflecting that it was a hardship for them to receive support medication at a facility other than their provider's office." *Id.* at 44. As NMOHC's expert stated:

> By requiring elderly NMOHC patients to purchase and receive certain oncology drugs at [Presbyterian]'s specialty pharmacy, Presbyterian effectively fragmented patient care by diverting these patients away from their oncology team at NMOHC who monitored all other aspects of their care, and outside the facility where they receive all other cancer testing, diagnoses, and support services.

Id.

NMOHC's expert went on to state that "such disruption could not only create confusion among patients, but also result in sub-optimal management of treatment, and put the patients at risk." *Id.* Presbyterian's implementation of the Mandate changed a preexisting, voluntary, and presumably profitable course of conduct between Presbyterian and NMOHC. *Id*. at 45. The benefits to the patient were substantial, so much so that the change prompted complaints from patients about the shift.

The district court concluded there is evidence that Presbyterian Health Plan ("PHP") dominates the relevant health insurance markets, including Medicare Advantage. *Id.* at 19. Indeed, the court assumed for purposes of its opinion that PHP possesses monopoly power. *Id.* Presbyterian is exercising this monopoly power by

forcing patients wanting Medicare Advantage coverage of chemotherapy drugs to purchase those drugs from the hospital when these patients would prefer to purchase the drugs from someone else—namely NMOHC—under different terms. The conditioning of patient Medicare Advantage coverage of chemotherapy support drugs on the patient's purchase of those drugs from the hospital is the essence of an antitrust tying violation. *See Eastman Kodak Co. v. Image Tech. Services, Inc*., 504 U.S. 451, 461-62 (1992); *Jefferson Parish Hosp. Dist. No 2 v. Hyde*, 466 U.S. 2, 12 (1984); *see also In re: Cox Enterprises*, *Inc.*, 871 F.3d at 1097 ("A tie exists when a seller exploits its control in one product market to force buyers in a second market into purchasing a tied product that the buyer either didn't want or wanted to purchase elsewhere."). The Mandate harmed patients and injured NMOHC by foreclosing the market for chemotherapy support drugs and stripping away NMOHC's drug revenue.

The district court's citation to *Four Corners Nephrology Associates, P.C. v. Mercy Med. Ctr. of Durango*, 582 F.3d 1216 (10th Cir. 2009), not only misses the mark, but instead, further demonstrates why this Court must consider the particular circumstances of the health care field and the underlying facts when reviewing this appeal. In *Four Corners*, the medical center's conduct was not simply for its own benefit, but vitally, it created significant benefits to patients, including greater access to care. *Id.* at 1223-24. The record in that case revealed that the defendant "a non-

profit entity, acted as it did merely to keep its practice from becoming so unprofitable that it would exhaust more rapidly than anticipated the reserves the hospital and tribe had set aside and leave the town and tribe without the benefit of a local nephrologist." *Id.* at 1225. There was no allegation in *Four Corners* that the defendant was trying to drive the doctor out of business, as is the case here. In fact, in *Four Corners*, there were allegations that the plaintiff had previously tried to open clinics with the purpose of forcing *his* competition to fail and leaving patients without local care. *Id.* at 1219. With those facts in mind and when viewed in context of the provision of health care, it is understandable that the plaintiff in *Four Corners* could not withstand a motion for summary judgment. That, however, is not the case here.

In sum, patients in this case were forced by Presbyterian's exercise of market power to deal exclusively with the hospital for their oncology drugs when they would have preferred for compelling clinical reasons to have obtained them from another source, NMOHC. This foreclosed NMOHC from the oncology drug market and constituted exclusionary monopoly conduct that enlarged Presbyterian's monopoly power in violation of Section 2. At the summary judgment stage, the substantial allegations of exclusionary conduct should be credited, and the district court should not have concluded that NMOHC's claims fail as a matter of law.

B. The nurse navigator program impaired NMOHC's ability to compete for patients, even when it might have been better able than Presbyterian to care for those patients.

Under the nurse navigator program, Presbyterian nurses would meet with patients newly diagnosed with breast cancer at a Presbyterian facility or at a facility of a business partner, Radiology Associates of Albuquerque, where Presbyterian rented space. *See* Dkt. 848 at 54. These nurses would attempt to convince these patients to retain Presbyterian physicians, rather than NMOHC physicians, for their cancer treatment. The district court observed the following regarding this program:

> [O]n one occasion, Ms. Sullivan-Moore [one of the nurse navigators] 'tried to retain' and 'spoke extensively' to a patient who was 'unhappy with her oncology appointment at [Presbyterian],'" and accordingly, was staying with her [Presbyterian] surgeon but switching to medical and radiation oncologists at NMOHC. . . . Further, there is evidence that on another occasion, a [Presbyterian] nurse navigator told an NMOHC patient that because of changes in [Presbyterian's] insurance plans, he/she would no longer be able to go to NMOHC; this was not accurate, and the patient was able to continue care at NMOHC. . . . On at least two other occasions, NMOHC patients reported to NMOHC staff that [Presbyterian] nurse navigators scheduled appointments for them with [Presbyterian] oncologists, although [they] were already established patients at NMOHC.

Id. at 61.

As explained above, nurses have an ethical obligation to serve their patients' interests first and foremost. Moreover, they are not to pressure patients unduly regarding treatment decisions. These general proscriptions apply even more strongly when the patients are informed that they have breast cancer and are psychologically

most vulnerable. Presbyterian, as the nurses' employer, should not have induced the nurses to violate their ethical standards. Thus, the nurse navigator program at least to some extent involved illicit behavior.

Supreme Court cases have recognized that the dissemination of truthful and non-deceptive information is critical to the efficient operation of health care markets. *See, e.g.*, *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 765 (1976) ("the free flow of commercial information is indispensable"). Conversely, restraints that limit dissemination of information significantly affect patients' ability to choose optimal treatments for their illnesses, thus causing market inefficiencies or failures. *See, e.g.*, *Improving Health Care* at 17.

The nurse navigator program was essentially an information restraint imposed by Presbyterian on physician referrals. Efforts to insulate dominant competitors through information restraints are quintessentially anticompetitive. *See Bates v. State Bar of Arizona*, 433 U.S. 350, 377-78 (1977); *F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447, 459 (1986); *see also Eastman Kodak Co.*, 504 U.S. at 473-475 (finding that the inability of consumers to acquire information can insulate manufacturers from competition).

Referral decisions made by a physician do not belong to the physician's employer. Rather, the referral decision ultimately belongs to the patient, who is

entitled to receive candid advice from his or her physician. As discussed above, the physician owes an obligation to the patient to exercise independent medical judgment for the benefit of the patient when referring the patient to a specialist. When an employer pressures physicians and/or patients with respect to a referral decision, the employer is both interfering with the competitive process and the patient's treatment.

The facially anticompetitive nature of the information restraint is not offset by any legitimate procompetitive benefit. In fact, the district court here did not even consider whether the conduct produced any such effect. Instead, the district court believed that the information restraints would make the hospital more profitable. The district court's rationale is nothing more than a claim that competition will harm consumers, which is not a permissible procompetitive justification. *See National Soc. of Professional Engineers v. U.S.*, 435 U.S. 679, 695 (1978).

All of this suggests the following questions:

- When the nurse navigators unduly pressured or misdirected their patients, was this a result of unreasonable pressure by Presbyterian, or was it simply an independent decision of the nurses in question?
- Were there persistent instances of undue pressure on or misdirection of patients?

- Most importantly, were the instances of undue pressure or misdirection sufficiently substantial that they were likely to influence the decision of an actual or potential competitor (not just NMOHC) whether to enter or expand into the independent (independent of Presbyterian, that is) business of treating breast cancer patients in or near Albuquerque?

The answer to all of these questions is the same—maybe. These are inherently factual issues, to be decided after a full hearing, when the factfinder will have the opportunity to place these possibly disparate data points into context. *See, e.g.*, *Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I.*, 311 F. Supp. 3d 468, 472 (D.R.I. 2018) (refusing to grant summary judgment on antitrust claims in the health care field in "close case"). If the answers are yes—and for summary judgment purposes they must be presumed to be—the lower court should be reversed.

CONCLUSION

Amicus curiae contends that the deterrent effect of antitrust law to prohibit these anticompetitive practices will be severely compromised if the district court's decision is not reversed. NMOHC was committed to providing quality patient care at an affordable cost, while Presbyterian was focused on maximizing its balance sheet regardless of the impact on patients. If Presbyterian's misconduct and practices like it are not reigned in through the enforcement of antitrust provisions, patients and

the health care field will suffer as dominant market forces destroy physician-run practices and eliminate competition.

To assure that anticompetitive restraints do not improperly restrict physician medical judgment, and thus, the quality of health care services, this Court should reverse the grant of summary judgment and remand for further proceedings.

July 6, 2020

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMIT

This brief complies with the type-volume limits because, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) (cover page, disclosure statement, table of contents, table of citations, statement regarding oral argument, signature block, certificates of counsel, addendum, attachments), this brief contains 4,022 words, based on the "Word Count" feature of Microsoft Word.

This brief complies with the typeface and type style requirements because this brief has been prepared in a proportionally-spaced typeface using Microsoft Office Word in 14-point Times New Roman.

July 6, 2020

s/ Kyle A. Palazzolo
Kyle A. Palazzolo

Counsel for Amicus Curiae

CERTIFICATE OF SERVICE

I hereby certify that on July 6, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Tenth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

July 6, 2020

s/ Kyle A. Palazzolo
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