The Financial Services Innovation Coalition Presents:

The State of Black Entrepreneurs in the Business of Healthcare And the 340B Drug Pricing Program

An FSIC Healthcare Inclusion Task Force Event

Wednesday January 22, 2025
Networking and Panel Discussion 4-6 pm
Bronzeville Winery
4420 S. Cottage Grove
Chicago, IL 60653

A Compendium of select Legislation and Articles

This compendium is a curated collection of writings detailing healthcare disparities in minority communities and lack of diversity in medical facility ownership

Assembled By:

Financial Services Innovation Coalition (FSIC)

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Financial Services Innovation Coalition (FSIC) and Southern Christian Leadership Conference (SCL-GPI) Invite you to its 3rd Annual Minority Policy Summit
Register Today!

Healthcare Facility Ownership Diversity Bill Outline

Outline for Health Equity Legislation – Dr. Wendy Muhammad Key Points for draft of Legislation

- Increase ownership diversity
- Financial support for ownership in areas where there are healthcare deserts.
- Financially support Providers that address primary comorbidities among Black and Hispanic Communities
- Address and protect our institutions from Unfair, discriminatory, and Anti-competitive business practices
- Government subsidies that prevent price gouging and credit manipulation for inventory and supplies
- Prevent manipulation of government regulatory agencies by larger institutions
- Support medicare/medicaid Patient referrals to minority owned institutions

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Ensuring adequate oversight of the 340B drug discount program bill

IN THE HOUSE OF REPRESENTATIVES

Mr. JACKSON of Illinois submitted the following resolution; which was referred to the Committee on

RESOLUTION

Ensuring adequate oversight of the 340B drug discount program.

Resolved, That—

(1) at least once per calendar year, the full Committee on Energy and Commerce of the House of Representatives shall conduct an oversight hearing on the drug discount program established under section 340B of the Public Health Service Act (42 U.S.C. 256b) (hereinafter referred to as the ''340B program'') with full opportunities for majority and minority witnesses and outside testimony submission;

(2) the Chair of such Committee shall request the Administrator of the Health Resources and Services Administration—

(A) to testify at such hearing as to the functioning and condition of the 340B program, with an emphasis on program integrity with respect to health equity concerns;

(B) to make himself or herself available for written questions after the fact from committee members;

(C) to respond to such questions not later than 60 days from receiving such questions in writing;

(D) to produce an annual report for public consumption on the state of the 340B program, including—

(i) a description of the health equity goals of such program;

(ii) a description of the Department of Health and Human Services' investment in communities surrounding 340B program facilities; and

(iii) a description of any transparency requirements placed on such facilities and any oversight conducted of such facilities; and

(E) to encourage nonprofit health care-based organizations to create public-private partnerships to assist with 340B program-re-

lated education and outreach efforts to vulnerable populations residing in rural and urban areas and to provide grant opportunities in the furtherance of such efforts; and

(3) the Chair of such Committee, in coordination with the ranking member of such Committee, shall submit any report produced under paragraph (2)(D) to the Comptroller General of the United States and shall request that the Comptroller General report back to such Committee and analysis of such report not later than 180 days after receiving such report.

Letter to President Biden – Subject: Healthcare Facility Ownership Diversity

March 27, 2024 (updated July 2024)

President Joeseph Biden
The White House
1600 Pennsylvania Avenue, NW
Washinton, DC 20500

Dear President Biden,

As a group of minority-owned and/or minority-serving healthcare institutions, we are writing to you regarding your health equity program. We respectfully request a meeting with you and/or your staff around this very important and complicated issue. There is much conversation around healthcare equity and disparity as it relates to patients, but the equity challenges facing minority-owned and/or minority-serving healthcare institutions are most often unknown and overlooked.

As healthcare facility owners, we know that ownership diversity is critical to any attempt to address a large number of healthcare deserts in our country. According to the GoodRx Research Team, in their 2021 report entitled, Mapping Healthcare Deserts, "More than 80% of counties across the U.S. lack adequate healthcare infrastructure in some shape or form. That means that over a third of the U.S. population lives in a county with less than adequate access to pharmacies, primary care providers, hospitals, trauma centers, and/or low-cost health centers. Healthcare deserts are more likely to affect those who face additional barriers to access, such as lower income, limited internet access, and lack of insurance. Together, these barriers can further widen disparities in health outcomes."

Additionally, we know that African Americans and Hispanics fall victim to cardiovascular disease and related risk factors such as diabetes at alarming rates. For example, according to the American Heart Association, "Based on 2015 to 2018 data, among non-Hispanic Black adults 20 years of age and older, 60.1% of males and 58.8% of females had cardiovascular disease." And, treatments for the underlying risk factors, such as Insulin, are not readily accessible in approximately 800+ counties in the US.

Based upon our experience, we believe that increasing the number of minority owned healthcare facilities will help to address healthcare equity. A study of county-level health data led by the Health Resources and Services Administration concluded that, on average, every 10% increase in the representation of Black primary care physicians was associated with 30.6 days of greater life expectancy among Black people in that

county. “Can we say that if a Black patient has a Black doctor, they will have better health outcomes? Yes, we can, because the evidence shows Black doctors provide better care for Black patients,” says Karey Sutton, PhD, scientific director of health equity research at the MedStar Health Research Institute in Maryland. Previously, as director of the health equity research workforce at the AAMC, Karey oversaw a systematic literature review (not yet published) of 3,000 studies on the impact of physician and patient race.

There are two major stumbling blocks to increasing the number of minority-owned health facilities: 1. Funding and 2. Anti-competitive behavior by industry and government actors.

1. Funding for Minority-owned health facilities – Given the relatively low income and wealth levels in many of the health deserts, it is reasonable to look at sources such as 340B allocations to help finance facility developments in these areas. The same can be said for rural development funds.
2. Unfair, discriminatory, and Anti-competitive practices – Many of us in this letter have been targeted for unfair, discriminatory, and anti-competitive treatment in our businesses. Large hospital systems, including university health systems, have worked to destroy our businesses. Many of us face false accusations from dark money-funded publications and intra-industry slander, as well as unfair treatment and neglect within the healthcare industry, aggressive regulatory enforcement that often results in threats against our medical licenses, facility and equipment credentialing, frivolous lawsuits, higher malpractice insurance rates, and even physical threats.

We believe the Departments of Health and Human Services and Justice should investigate many of these actions, and we are willing to provide detailed information on our experiences and how these practices have negatively impacted our businesses.

Please contact Brady J. Buckner, President, FSIC, at bbuckner@fsicoalition.org or 202-680-4749 to discuss possible times for a meeting. Thank you in advance for your consideration.

Sincerely,

Kevin B. Kimble, Esq.
CEO and Founder
FSIC

Wendy Muhammad
Business Developer
Chairperson, FSIC Health Equity Task Force

Dr. Doriann Thomas, MD
Board Certified Radiologist
Laurel Radiology
Laurel, Maryland

Dr. Innocent Ubunama, DO
Board Certified General Surgeon
Midwest Vascular and Varicose Vein Center
Holland, Ohio

Dr. James McGucken
Interventional Radiologist
Pennsylvania Vascular Institute
Philadelphia, Pennsylvania

Dr. Ayana Seibles, DO
Quadruple Board-Certified in Emergency Medicine,
Internal Medicine, Vascular & Endovascular Medicine
Maryland, Virgina, DC

Dr. Steven A. Price, DDS
Washington Smile Center
Washington DC and Maryland

Vannie L. Taylor, IV, D.D.S.,
Largo Bright Smiles,
Prince Georges County, Maryland

Dr. Augustus Hill Jr, MD
General Surgery, Gastroenterology
Washington DC Maryland

Larry McKinney
Capital Radiology
Laurel, Maryland

Dr. Jeffery J. Dormu, D.O., FACOS
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and General Surgeon
Founder,
Minimally Invasive Vascular Center
Laurel Maryland

Ifeoma C. Udoh, Ph.D
EVP Policy Advocacy and Science
Black Women’s Health Imperative (BWHI)

Data Sources:

1. GoodRX Mapping Healthcare Deserts Report
   https://assets.ctfassets.net/4f3rgqwzdznj/1XSl43l40KXMQiJUtl0iIq/ad0070ad4534f9b5776bc2c41091c321/GoodRx_Healthcare_Deserts_White_Paper.pdf
2. American Heart Association: 2022 Heart Disease & Stroke Statistical Update Fact Sheet
   Black Race & Cardiovascular Diseases
   https://professional.heart.org/-/media/PHD-Files-2/Science-News/2/2022-Heart-and-Stroke-Stat-Update/2022-Stat-Update-factsheet-Black-Race-and-CVD.pdf
3. AAMC Article:
   Do Black Patients fare better with Black doctors?
   https://www.aamc.org/news/do-black-patients-fare-better-black-doctors#:~:text=A%20study%20of%20county%2Dlevel,Black%20people%20in%20that%20county.66

Article:
Mayor Stoney asks for investigation after bombshell report on Bon Secours

Richmond Mayor Levar Stoney shared a statement on Tuesday afternoon calling for an investigation into the use of a lucrative drug program by Bon Secours following a NYT investigation.

By: WTVR CBS 6 Web Staff
Posted at 3:47 PM, Sep 27, 2022
and last updated 6:31 PM, Sep 27, 2022

RICHMOND, Va. -- Richmond Mayor Levar Stoney shared a statement on Tuesday afternoon calling for an investigation into the use of a lucrative drug program by Bon Secours following an investigation from the New York Times over the weekend.

"We strive to build equity into everything we do, and expect organizations serving our community to share those values," Stoney said in a tweet.

Also included in Stoney's tweet was a full request for an investigation made to Xavier Becerra, the Secretary of the Department of Health and Human Services.

The story, which was initially reported by the New York Times on Saturday, cited many former and current employees of Richmond Community Hospital alleging its owner Bon Secours has slashed resources from the hospital over the years. The article outlined diminishing support for Richmond Community came as Catholic-based Bon Secours utilized the hospital to rake in hundreds of millions of dollars in profits through a lucrative drug program called 340B.

The law allows non-profit hospitals that avoid paying taxes, like Bon Secours, which serves low-income communities, to buy medication for half the cost while still billing patients and insurance companies close to full price. The goal is to incentivize Bon Secours to use those savings to invest back into the facility and the disadvantaged area that it serves.

However, sources told the New York Times that much of the money saved through the program does not go toward those efforts as Richmond Community Hospital lacks basic tools and resources to treat patients. Some healthcare workers said the circumstances have placed them in positions of not being able to care for patients in dire need properly.

CBS 6 Problem Solver Tyler Layne spoke with some Richmonders about the story on Monday. One woman, who said her family member relies on Bon Secours for infusions that are critical to that person's health, said the report "felt like a punch in the gut".

Virginia Senator Tim Kaine also commented on the story, saying that the Richmond Community Hospital is "an absolutely critical program," and "the thought that somebody might be using this program as a profit center as opposed to really helping people was very troubling."

"Free clinics, community health centers, many hospitals who provide care to the poor and folks who really need health care, they rely on this program to bring down the cost of prescription drugs for the most-needy communities in Virginia and throughout the country," Kaine said.

This is a developing story, so anyone with more information can email newstips@wtvr.com to send a tip.

FSIC Op-ed:
Minority-Owned Healthcare Facilities Critical in Fight Against Health Inequity

An FSIC Healthcare Task Force Op-ed
By: Dr. Wendy Muhammad
Dr. Jeffery J. Dormu, D.O., FACOS
Larry McKinney
March 28, 2024

As healthcare facility owners, we know that ownership diversity is critical to any attempt to address a large number of healthcare deserts in our country. According to the GoodRx Research Team, in their 2021 report entitled, Mapping Healthcare Deserts, "More than 80% of counties across the U.S. lack adequate healthcare infrastructure in some shape or form. That means that over a third of the U.S. population lives in a county with less than adequate access to pharmacies, primary care providers, hospitals, trauma centers, and/or low-cost health centers. Healthcare deserts are more likely to affect those who face additional barriers to access, such as lower income, limited internet access, and lack of insurance. Together, these barriers can further widen disparities in health outcomes."

Additionally, we know that African Americans and Hispanics fall victim to cardiovascular disease and related risk factors such as diabetes at alarming rates. For example, according to the American Heart Association, "Based on 2015 to 2018 data, among non-Hispanic Black adults 20 years of age and older, 60.1% of males and 58.8% of females had cardiovascular disease." And treatments for the underlying risk factors, such as Insulin, are not readily accessible in approximately 800+ counties in the US.

Based upon our experience, we believe that increasing the number of minority owned healthcare facilities will help to address healthcare equity. A study of county-level health data led by the Health Resources and Services Administration concluded that, on average, every 10% increase in the representation of Black primary care physicians was associated with 30.6 days of greater life expectancy among Black people in that county. "Can we say that if a Black patient has a Black doctor, they will have better health outcomes? Yes, we can, because the evidence shows Black doctors provide better care for Black patients," says Karey Sutton, PhD, scientific director of health equity research at the MedStar Health Research Institute in Maryland. Previously, as director of the health equity research workforce at the AAMC, Karey oversaw a systematic literature review (not yet published) of 3,000 studies on the impact of physician and patient race.

There are two major stumbling blocks to increasing the number of minority-owned health facilities: 1. Funding and 2. Anti-competitive behavior by industry and government actors.

1. Funding for Minority-owned health facilities – Given the relatively low income and wealth levels in

many of the health deserts, it is reasonable to look at sources such as 340B allocations to help finance facility developments in these areas. The same can be said for rural development funds.
2. Unfair, discriminatory, and Anti-competitive practices – Many of us in this letter have been targeted for unfair, discriminatory, and anti-competitive treatment in our businesses. Large hospital systems, including university health systems, have worked to destroy our businesses. Many of us face false accusations from dark money-funded publications and intra-industry slander, as well as unfair treatment and neglect within the healthcare industry, aggressive regulatory enforcement that often results in threats against our medical licenses, facility and equipment credentialing, frivolous lawsuits, higher malpractice insurance rates, and even physical threats.
The White House and Congress should act now to protect these vital components of our healthcare infrastructure.

About: The FSIC Healthcare Equity Task Force comprises heathcare experts, practitioners, and stakeholders committed to improving the discourse around healthcare accessibility and healthcare.

The Financial Services Innovation Coalition (FSIC) is a growing network of Industry Innovators, Legislators, Community Groups, and Academics who are passionate about applying emerging technology and market innovation to create a more inclusive economy. FSIC advocates for policy that promotes economic empowerment in underserved communities. FSIC believes that with improved economic opportunities in minority communities, the economy will improve significantly, benefiting ALL Americans.

Data Sources:
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5. American Heart Association: 2022 Heart Disease & Stroke Statistical Update Fact Sheet
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https://professional.heart.org/-/media/PHD-Files-2/Science-News/2/2022-Heart-and-Stroke-Stat-Update/2022-Stat-Update-factsheet-Black-Race-and-CVD.pdf
6. AAMC Article:
Do Black Patients fare better with Black doctors?
https://www.aamc.org/news/do-black-patients-fare-better-black-doctors#:~:text=A%20study%20of%20county%2Dlevel,Black%20people%20in%20that%20county.66

Article: 'Pharmacy Deserts' Disproportionately Affect Black and Latino Residents in Largest U.S. Cities

By USC Schaeffer Center
May 3, 2021
Press contact:**Jason Millman**(213)-821-0099

Black and Latino neighborhoods in the 30 most populous U.S. cities had fewer pharmacies than white or diverse neighborhoods between 2007-2015, USC research shows, suggesting that 'pharmacy deserts' — like so-called food deserts — may be an overlooked contributor to persistent racial and ethnic health disparities.

Pharmacies are increasingly vital points of care for essential health services. In addition to filling prescriptions to treat chronic health conditions, pharmacists dispense emergency doses of naloxone to reverse opioid overdoses, contraceptives to prevent unplanned pregnancy and COVID-19 testing and vaccinations.

But many neighborhoods in major cities such as Los Angeles, Chicago, Houston and Memphis lack convenient access to a pharmacy, according to research published today in the May issue of Health Affairs.

"We focused on cities because of racial/ethnic residential segregation and the fact that more than 80% of the Black and Latino population in the U.S. live in cities," said senior author Dima Mazen Qato, Hygeia Centennial Chair and associate professor of pharmacy at the USC School of Pharmacy and senior fellow at the USC Schaeffer Center for Health Policy & Economics. "Our findings suggest that addressing disparities in geographic access to pharmacies — including pharmacy closures — is imperative to improving access to essential medications and other health care services in segregated minority neighborhoods."

One in three neighborhoods pharmacy deserts

"One in three neighborhoods throughout these cities were pharmacy deserts, affecting nearly 15 million people," said Jenny S. Guadamuz, the study's first author and postdoctoral fellow at the USC Schaeffer Center and the Program on Medicines and Public Health at the School of Pharmacy. "However, limited access to pharmacies disproportionately impacts racial/ethnic minorities — 8.3 million Black and Latino residents of these cities live in deserts."

Researchers focused on census tracts/neighborhoods in cities with populations of 500,000 or more. Census tracts, smaller than ZIP code areas, generally have a population size between 1,200 and 8,000 people. Data from the U.S. Census Bureau's American Community Survey established neighborhood characteristics including total population, percentage of the population by race/ethnicity, low-income status and vehicle ownership. Pharmacy locations and types of pharmacies came from the National Council for Prescription Drug Programs.

Researchers overlaid census tract maps with pharmacy locations. Neighborhoods where the average distance to the nearest pharmacy was 1.0 mile or more were classified as pharmacy deserts. In neighborhoods that were low income and had at least 100 households with no vehicle, the qualifying distance dropped to 0.5 miles or more to account for transportation barriers.

"Traveling a mile to get your prescription medications may be convenient for people that own a car. Traveling a mile, or even half a mile, may be difficult for people who live in low-income neighborhoods and don't drive, particularly older adults who rely on walking or public transportation," Qato said.

Stark disparities in Los Angeles

Prevalence of pharmacy deserts varied widely across cities. In New York and Philadelphia, for example, fewer than 10% of neighborhoods met the definition of pharmacy deserts. On the other hand, more than 60% of neighborhoods in Indianapolis, San Antonio and Charlotte were pharmacy deserts.

In all cities, segregated Black or Latino neighborhoods, or both, were more likely to be pharmacy deserts than white or diverse neighborhoods. These disparities were most pronounced in Los Angeles, Chicago, Albuquerque, Dallas, Memphis, Boston, Milwaukee, Baltimore and Philadelphia.

"We observed stark disparities in Los Angeles, where one-third of all Black and Latino neighborhoods were pharmacy deserts, particularly neighborhoods in South Central L.A., including Florence, Broadway-Manchester and Watts," Guadamuz said.

Among all the cities examined, the most pronounced disparities were in Chicago, where 1% of white neighborhoods were pharmacy deserts in comparison to 33% of Black neighborhoods in the South Side neighborhoods of Chatham, West Pullman and Greater Grand Crossing, Guadamuz added.

The researchers said policies could help address the situation. For example, federal, state and local governments could deploy targeted grants and tax benefits to encourage pharmacies to locate in pharmacy deserts. Other incentives could motivate pharmacies to offer services such as home delivery to improve access.

“Increasing Medicaid and Medicare pharmacy reimbursement rates for prescription medications might encourage pharmacies to open in areas of need,” Guadamuz said. “To ensure existing pharmacies don’t close, policymakers need to make sure that stores serving Black and Latino areas are not excluded from pharmacy networks.”

About the study

In addition to Qato and Guadamuz, study authors include Jocelyn R. Wilder of the University of Illinois at Chicago; Morgane C. Mouslim of the University of Baltimore; Shannon N. Zenk of the National Institute of Nursing Research; and G. Caleb Alexander of the Johns Hopkins Bloomberg School of Public Health.

Funding for this study was provided by the National Institute on Aging (Qato, Grant No. R21AG049283) and the Robert Wood Johnson Foundation (Qato, Guadamuz and Zenk).

FSIC Meeting Request Letter to the Department of Justice (DOJ) Healthcare Antitrust Task Force

June 4, 2024 (Updated July 2024)

Katrina Rouse
Director
Healthcare Monopolies and Collusion Task Force
U.S. Department of Justice

Dear Ms. Rouse,

We are writing to congratulate you on the creation of the Healthcare Antitrust Task Force. There is much conversation around healthcare equity and disparity as it relates to patients, but the equity challenges facing minority-owned and/or minority-serving healthcare institutions are most often unknown and overlooked.

As minorities in the healthcare industries who own and operate facilities in various cities across the country, many of us have faced very aggressive anticompetitive actions from the larger Private Equity and Venture Capital backed healthcare facilities in our communities. We have been attacked by the large university hospital systems as well as the large for-profit systems that have worked tirelessly to destroy our businesses. Tactics include false accusations from dark money-funded publications and intra-industry propaganda, as well as unfair treatment and neglect within the healthcare industry, aggressive regulatory enforcement that often results in threats against our medical licenses, facility and equipment credentialing, frivolous lawsuits, higher malpractice insurance rates and even physical threats.

In other cases, collaborations between larger hospital systems, insurance companies, and private equity firms have forced our patients to receive services from their systems by denying us referrals and reimbursements, aggressively recruiting our key personnel, ghosting patients, spying, and even slandering our facilities and service providers.

These attacks weaken our businesses leaving them vulnerable and the community fodder for monopoly and manipulation. Not only that, but we then are also left with patients who have been untreated, misdiagnosed, and neglected because they are in the advanced stages of their disease process and are not ideal “customers” for these profit-centered institutions. Our elected officials and administrative agencies have worked to help close down our

facilities with bogus and aggressive reviews and investigations.

Health inequity will not be overcome without adequate minority healthcare ownership. Our rural and urban communities cannot access any of the benefits of improved health innovation if they cannot access health facilities at all. As healthcare facility owners, we know that ownership diversity is critical to any attempt to address the large number of healthcare deserts. According to the GoodRx Research Team, in their 2021 report entitled, "Mapping Healthcare Deserts," More than 80% of counties across the U.S. lack adequate healthcare infrastructure in some shape or form. That means that over a third of the U.S. population lives in a county where there is less than adequate access to pharmacies, primary care providers, hospitals, trauma centers, and/or low-cost health centers. Healthcare deserts are more likely to affect those who face additional barriers to access, such as lower income, limited internet access, and lack of insurance. Together, these barriers can further widen disparities in health outcomes."

We request the opportunity to be included in this task force and wish to express some concern that we were not included in its creation nor asked to participate in any of its meetings. Our unique experiences will offer additional valuable data as you seek to address this corrosive denigration of our healthcare infrastructure and work to stop the healthcare devastation that is rampant in our country. Should you wish to discuss these issues, please contact us at 202-696-0138.

Sincerely,

Kevin B. Kimble, Esq.
CEO
Financial Services Innovation Coalition

Brady J. Buckner
President
Partnership for Innovation
and Empowerment (PIE)

Pamela WarnerDr.
Founder and CEO
Good Healthcare Matters, LLC

Dr. Doriann Thomas, MD
Board Certified Radiologist
Laurel Radiology

Dr. James McGucken
Interventional Radiologist
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EVP Policy Advocacy and Science
Black Women's Health Imperative (BWHI)

Dr. Charles Steele, Jr.
President
Southern Christian Leadership Conference

Sajdah Wendy Muhammad
International Business and RE Developer
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Dr. Lucenia Dunn
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Vannie L. Taylor, IV, D.D.S.,
Largo Bright Smiles,

Larry McKinney
Capital Radiology

Dr. Meigan Fields, Ph.D.
Advisor
FSIC Minority Policy Priorities Task Force

cc: Jonathan Kanter, Assistant Attorney, U.S. Department of Justice

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