Point32Health

August 31, 2022

Dr. Meena Seshamani
Director, Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Medicare Program Request for Information (August 2022) Submitted via Regulations.gov

Dear Director Seshamani:

On behalf of Point32Health, I am pleased to provide comments on the *Medicare Program; Request for Information on Medicare* (Medicare RFI), published on August 1, 2022 (87 FR 46918).

Point32Health is a leading health and wellbeing organization, providing benefits and services across New England. Our family of companies includes Tufts Health Plan and Harvard Pilgrim Health Care, and we cover 2.2 million members across Connecticut, Maine, Massachusetts, New Hampshire, and Rhode Island. We offer all lines of health coverage, including Medicare, Medicaid, and commercial plans. In addition, we cover the vulnerable individuals dually eligible for Medicare and Medicaid as well as those purchasing subsidized qualified health plans through the Marketplace. Our family also includes the Point32Health Foundation which invests in communities throughout our New England footprint.

We consistently rank among the top health plans in the country regarding quality and member satisfaction. For the seventh year in a row, Tufts Health Plan earned 5 out of 5 stars for its Tufts Medicare Preferred HMO plan from the Centers for Medicare and Medicaid Services (CMS) in its annual Star quality ratings for 2022. CarePartners of Connecticut, our Medicare Advantage plan in Connecticut and one of the fasting growing Medicare Advantage plans in the state, has been recognized for its quality and performance with a prestigious 4.5 Star rating for its first Star quality ratings year in 2022.

The Value of Not-for-Profit Health Care

As a not-for-profit health plan, we have strong ties with our local communities where we partner with providers through value-based arrangements and invest in the health of our overall communities. We are proud that Point32Health was recently recognized as one of the 50 most community-minded companies in the nation by Points of Light, the world's largest nonprofit dedicated to volunteer service.[1]

Our not-for-profit mission encompasses our *entire* community. Therefore, some of our initiatives are available outside of our member base. For instance:

[1] See the announcement at https://www.pointsoflight.org/press-releases/points-of-light-releases-the-civic-50-key-trends-and-insights-2022-report/.

- **Mobile COVID-19 Vaccination Clinic:** To address vaccine hesitancy in socially vulnerable areas in Massachusetts, we partnered with minority-owned firms, health centers and other community partners to retrofit a full-size bus into a vaccination clinic and brought it to vulnerable communities to increase vaccine take-up for everyone in the community, even those that are not our enrollees.

- **Rural Health Clinic:** Point32Health is preparing to launch the Northern New Hampshire Mobile Health Clinic which will offer access to some of the most needed services in these rural communities. The Clinic will bring health care to North Country (rural, northern NH) residents both in person and through telehealth services by offering preventative screenings, immunizations, wellness education, and social services via a mobile clinic staffed by local community providers. The Clinic will also provide greater accessibility for current patients of community providers through expanded visit locations, including at home. The clinic predicts 2,500 visits throughout northern New Hampshire in 2022 and plans on administering flu/COVID-19 vaccines, connecting individuals who haven't seen a doctor in a year to a local PCP, triaging individuals to behavioral health and SUD programs, connecting individuals to food security services, increasing health literacy and offering community wellness education events.

- **Early Financial Support for Providers when COVID-19 Emerged**: When the COVID-19 pandemic arrived in early 2020, we quickly mobilized to help our members, employers, providers, and communities navigate the myriad and unfamiliar challenges everyone suddenly faced. Along with substantial financial support for our communities, we also responded with very real and meaningful actions that provided a critical bridge for providers as they waited for the federal government to first approve, and then disburse funding. For example, we provided $3 million to independent primary care practices to assist with opening their practices in accordance with COVID-19 guidelines, through Harvard Pilgrim Health Care. We also worked with providers on a case-by-case basis to address their concerns regarding payment stability.

We are committed to delivering personalized, holistic care to our members. This requires us to understand the diverse positions of our members regarding their health, culture, family, socio-economic challenges, and other factors. It requires sensitivity and innovation. The following items are examples of some of our member-facing initiatives:

- **Culturally Competent On-Boarding and Navigation**: We currently participate in the One Care market with Tufts Health Unify, a Medicare-Medicaid Plan (MMP) specifically designed to serve under 65 Medicare eligibles who also qualify for Medicaid, as well as Senior Care Options, a fully integrated dual eligible special needs plan (FIDE SNP) serving individuals aged 65 and over. As part of these products, Point32Health has developed a culturally competent onboarding and engagement process beginning at the onset of member's coverage to identify member's needs and preferences in language and other areas. This approach leads to (1) members better understanding their coverage, (2) members receiving materials and go forward communications in preferred formats and languages, (3) a care team composition that is culturally responsive to member preferences and (4) care management staffing that is attuned to the communities we serve. In addition to this approach, Point32Health monitors key metrics by race, ethnicity, and language to ensure our initiatives and strategies are responsive to and reflective of the communities we serve.

  As a result of these efforts, we are proud to have achieved a COVID-19 vaccination rate of nearly 89% for members in our Senior Care Options (SCO) plan that serves individuals dually eligible for both Medicare and Medicaid.

- **Pharmacy Equity Pilot:** Our pilot seeks to drive equal prescription drug access and improved adherence to medications. The project proactively provides medication cost counseling and interventions to clinically complex underserved members enrolled in our Massachusetts MA plans. The target geography was determined by focusing on the 20 underserved towns identified during COVID-19 vaccine outreach.
- **Memory and Dementia Care:** Tufts Health Plan Medicare Preferred collaborates with the Massachusetts and New Hampshire Alzheimer's Association chapters to provide a groundbreaking program for our members. We assign a Dementia Care Consultant who works with the member, their family, and their primary care physician to develop a plan to optimize independence, secure additional needed resources, learn strategies for symptom management, and plan for future needs.
- **Behavioral Health Guidance:** For certain members coping with chronic behavioral health conditions, we assign a Behavioral Health clinician to act as the member's personal advocate to assist in finding behavioral health providers; provide education on behavioral health conditions, medications, and symptoms; coordinate a care plan in collaboration with medical providers and identify additional resources available through community and government programs.

Our Recommendations

We applaud the bold vision that CMS released and strongly support its six pillars: Advance Equity, Expand Access, Engage Partners, Drive Innovation, Protect Programs and Foster Excellence. The pathways to achieve these pillars may often include the same initiatives. For instance, specific policies that advance equity may also result in fostering excellence. Given that a single CMS initiative can have impacts on multiple priorities, we have grouped our recommendations in other categories below and then described how these will advance – or set back – specific CMS pillars. In order to advance *all of the pillars*, we urge you to:

1) **First, Do No Harm.** We are very concerned CMS may be finalizing the Trump Administration's 2018 Proposed RADV Rule[2]. This proposal would audit 201 enrollees in an MA plan to determine if their MA risk scores were incorrect according to coding rules. The error rate would then be extrapolated across the entire contract (e.g., thousands of members). This policy would apply *retroactively* to 2011. Furthermore, the proposed rule eliminated the fee-for-service (FFS) adjuster, which is needed to ensure actuarial equivalence between payments to MA plans and payments under FFS.

   Twelve not-for-profit organizations – representing over 80 not-for-profit health plans – have expressed significant concern that finalization of this policy could:

   - **Destabilize not-for-profit health plans**. These health plans carry narrow margins and are especially vulnerable to policy swings impacting finances. The Medicare Advantage market is already consolidating with the top three for profit plans controlling 55 percent of the market in 2020. In 2022, 85 percent of all new enrollment went to for-profit plans.
   - **Penalize value-based care providers**. As a result of the value-based contracts with many MA Plans, any retroactive recoupment from MA plans could trigger large financial recoveries from downstream providers. This could create financial problems for health providers who are still

[2] See 83 FR 54982.

reeling from COVID struggles. Furthermore, this would create a sentinel impact where providers would be hesitant to agree to value based contracts in the future.

- **Hurt health equity.** Nearly 50% of Black and 54% of Latinx older adults are enrolled in MA. Low-income beneficiaries are especially dependent on low premiums and critical supplemental benefits. Retroactive recoveries could trigger premium increases or benefit reductions that unduly harm beneficiaries of color. In addition, RADV is likely to disproportionately hurt the plans and providers that serve minority communities. These providers may be less likely to have sophisticated coding infrastructure and minority patient records may be more likely to contain coding issues leading to higher error rates. While we support accurate coding, it is also important to recognize that coding errors do not necessarily mean that the beneficiary doesn't have the diagnosis. The coding error may be administrative rather than clinically substantive.

The proposed RADV rule is four years old and pre-dates the COVID-19 pandemic. Today's health system is already battered. We urge CMS *not* to finalize this rule. Instead, CMS should issue a *proposed* rule with a notice and comment period, allowing adequate time for stakeholders to analyze unintended impacts. We support program integrity and are committed to helping CMS achieve its integrity objectives in ways that do not thwart other critical CMS objectives such as health equity and value-based care. We have attached a more detailed letter from the coalition (see Appendix A).

2) **Collaborate to advance efficiency:** We want to optimize the dollars available to provide innovative services to members and invest in our communities. Ben Franklin once advised, "Watch the pennies and the dollars will look out for themselves." In this spirit, we recommend that CMS aid health plans in areas that will support administrative efficiency, such as:

- **Clinicians Practicing Across State Lines:** Enabling clinicians to utilize telehealth to serve patients in other states would increase needed access for underserved communities, such as rural areas. This would reduce the administrative cost of clinicians practicing in areas with small populations and better enable health plans to expand access to services.

- **Data Sharing:** We are concerned beneficiaries may experience "data fatigue" if asked multiple times for socio-economic data. Some of this data already has been gathered by local, state, or federal governments. In other cases, health plans or providers have gathered it. Having CMS create a secure way to pool race, ethnicity, and language (REL) data would increase its availability to all health stakeholders and follow members as they move through programs and the overall system.

- **Passive Enrollment:** Dual eligibles have greater SDoH, behavioral health and long-term support needs. This hinders their ability to engage with traditional sales and enrollment processes. A passive enrollment model, where the state Medicaid agency manages enrollment, would make integrated plans truly accessible to the most vulnerable populations while preserving critical member protections. Provision of both passive and active enrollment pathways allows members to engage with the program in the manner that best fits their needs. Having multiple points of entry also facilitates sustainable operational volume.

- **Establishment of Technical Advisory Groups:** In many cases, there are multiple technical ways to achieve CMS policy objectives. We urge CMS to utilize a technical group to advise on appropriate timing, synching, and specifications that simultaneously optimize efficiency and consumer benefits. For instance, IT resources are limited, and inefficient use precludes other IT

initiatives on health equity and quality. An advisory group of IT experts could help avoid this. Similarly, major policy initiatives such as those regarding drug negotiation may have spillover impacts if not crafted carefully. Ongoing communications with workgroups could be helpful in navigating these challenging areas.

- **Continue to Seek Stakeholder Feedback in Other Areas:** Point32Health appreciates this opportunity to provide feedback specific to the Medicare Advantage program. We urge CMS to also provide similar opportunities to offer feedback on other areas of the Medicare program. This includes, for example, issuing a Part D RFI to help address any obstacles to program sustainability.

  We also urge CMS to conduct more frequent engagement with stakeholders outside of the formal rulemaking process. We continue to believe that working groups, such as regular in-person meetings with MA organizations and Part D plan sponsors, will promote an innovative exchange of ideas and feedback to facilitate the development of practical solutions that identify and address the root cause of issues.

3) **Further Stability for Providers and Health Plans:** The COVID-19 pandemic has taken a toll on both providers and not-for-profit plans. While we are proud of our efforts to support our members, providers, and communities throughout the COVID-19 PHE, this work has resulted in significant unreimbursed costs for MA Organizations. This includes funding of initiatives such as coverage of at home over-the-counter (OTC) COVID-19 tests before coverage by Part B as well as exclusion of audio-only services from risk adjustment and artificial risk suppression. At Point32Health, we suffered $500 million in unreimbursed COVID-19 expenditures in 2020 and 2021 and we anticipate additional COVID impacts throughout 2022. We ask CMS to consider these ongoing COVID-19 struggles when evaluating the following:

   - **Artificial Risk Suppression:** As a regional not-for-profit health plan, we serve some of the most vulnerable residents in Massachusetts, Connecticut, and New Hampshire, including dually eligible individuals. The halt in normal utilization during the height of the PHE has, and will continue to, significantly diminish the completeness and accuracy of medical records and appropriate diagnosis capture. We are also concerned that any extended deferral of care could lead to higher case mix and costs because of conditions being diagnosed at a later stage of disease progression. To ensure stability in access and payment for enrollees, providers and the plans that serve them, we urge CMS to take steps to modify the existing risk adjustment model so as not to miss the higher costs of treating conditions in 2023 that went undiagnosed during the PHE.

     In 2020 and 2021, members cut back on provider visits where diagnoses are documented, but may have continued to use plan services (e.g. nutritional counseling, DME, etc.) that do not trigger higher risk scores. This artificially suppressed risk scores and reduced payment levels to plans (and our payments to providers). In addition, the existing risk adjustment model is likely to miss the higher costs of treating conditions in 2023 that went undiagnosed during the PHE and fails to incorporate diagnoses from audio-only patients. CMS should evaluate this artificial risk suppression and its impact on not-for-profit health plans and providers as well as other potential spillover impacts on future years. We also request that CMS provide guidance on the use of diagnoses from telehealth encounters to allow inclusion of audio-only technologies where clinically appropriate for all dates of service during which such services were covered.

- **Ending the COVID-19 PHE and the Commercialization of COVID-19 Treatments and Vaccines:** Given the extensive planning required for the transition, significant advance notice is required for both the end of the PHE and private market transition to being the primary distributor and payer for COVID-19 preventative therapeutics. We urge CMS to work with MA plans to address the significant procurement, operational and financial impacts of any transition. As part of this transition, it is critical that COVID-19 vaccines and therapeutics be appropriately priced when responsibility moves from the federal government to health insurance providers. Processes must be in place to ensure a competitive market that empowers the commercial market to negotiate, using available levers to ensure long-term affordability of health care access for all Americans.

  Furthermore, we urge CMS to make permanent certain flexibilities put in place during the PHE. This includes benefit design flexibilities The temporary waiver of the Medicare telehealth payment requirement should be made permanent, this includes extending the flexibility in benefit design for originating sites, eligible geographies, eligible services, and eligible providers.

- **STAR Rating Changes:** We recognize the value of this system for ensuring beneficiary access to high-quality, coordinated care. However, as the nation enters its third year of the COVID-19 PHE, providers still struggle to maintain day-to-day operations while dealing with staffing shortages, surges caused by new variants and even different PHEs (e.g., monkeypox). The health system does not yet have capacity to return to a pre-pandemic pace of policy changes. Therefore, we urge CMS to be thoughtful about which, if any, changes are made at this time. We would appreciate more collaborative opportunities with CMS to ensure that smaller plans are not driven from the market, and changes do not reduce benefits to members.

  We also support reevaluation of the type, number and weights of measures to ensure they are appropriate and achievable. For instance, given the system has still not recovered from COVID-19, appointment availability continues to be challenging. Therefore, applying a weight of 4 to CAHPS measures should be re-evaluated. Also, new HEDIS measures for Transition of Care and Follow-Up Post-Emergency Department Visits could be improved by removing the more administrative components and focusing on those that have a clinical/quality impact.

  As CMS takes steps to improve and streamline its approach to quality measurement, we recommend CMS engage stakeholders to align the various quality measurement approaches across programs. This will ultimately improve quality reporting, reduce administrative burden, and drive providers to invest in quality in collaboration with their plan partners.

- **Benchmark:** Medicare Advantage benchmarks are set using a robust methodology that considers the average spending per beneficiary in fee-for-service (FFS) Medicare, adjusted for the service area. By recognizing that utilization drives costs, the benchmark methodology helps to fund MA plans at a level that maintains benefits and keeps spending for the government for Medicare Advantage at or below the cost of FFS Medicare while encouraging health plans to lower costs, add extra benefits and meet high quality standards. Quality bonus payments incentivize quality performance and ensure that those payments are used to directly benefit enrollees.

  We urge CMS to ensure the underlying methodology reflects utilization patterns and that revenue aligns with local costs and expenses to support the high-quality care, beneficiary cost savings, and innovative benefits offered by Medicare Advantage plans. We also respectfully

request transparency and engagement of MAOs throughout the benchmark development process. The COVID-19 PHE, for example, affects numerous issues, such as projected costs that are incorporated into benchmarks and MA payment rates; the determination of MA enrollee risk scores; FFS risk scores included in the normalization factors for 2022; the completeness and accuracy of diagnoses captured through the encounter data system; and quality measures under the Star Ratings program. Collectively, this can lead to significant uncertainty for MAOs and Part D sponsors as they develop bids for the upcoming plan year. We urge CMS to clarify, in writing, the details of all assumptions and their impacts on base rates.

- **Stability for Medicare Providers:** Access to care is directly related to provider capacity. Medicare payment and delivery systems must incentivize and sustain provider capacity to ensure all beneficiaries have access to appropriate, quality care in a timely fashion. Currently, Medicare providers indicate they are burdened by unnecessary administrative complexities, competing regulatory requirements, inadequate payment rates and insufficient support to manage other financial and operational challenges. These obstacles have only been exacerbated by the COVID-19 PHE.

  Provider stability is particularly necessary in underserved communities, as well as in the areas of behavioral health and substance use disorder, both of which saw increases in demand for services during the COVID-19 crisis. For example, the current lack of psychiatric consultation on an outpatient basis has had a negative impact on quality of care for our members. While there are adequate counselors in other areas of mental health support, a psychiatrist is required to prescribe and monitor patients on psychotropic and other medications. As a result, our members have been forced to utilize Emergency Departments, resulting in higher admissions and readmissions.

  CMS can alleviate the financial burden on providers through loan forgiveness programs. A federal loan forgiveness program would be particularly beneficial for underserved communities, as well as in the areas of behavioral health and substance use disorders.

  We appreciate CMS' commitment to streamlining regulatory requirements and reducing administrative burdens placed on providers. These efforts directly correlate to an increase in the time and resources providers can dedicate to improving care and outcomes. Despite these efforts, much remains to be done to ease the burden placed on providers. As noted above, aligned quality reporting would prevent providers from having to comply with multiple and differing quality metrics.

4) Support Specific Innovations

Local and Regional Plans drive innovation and equitable access to person-centered care. We meet our members where they are. As a community-based health plan, we are in the best position to continuously take steps to identify and address the needs of our beneficiaries and to support the communities they live in. For example, Point32Health Medicare Advantage Care Management programs are designed to guide members through the healthcare system, ensuring they can access high-quality, coordinated care. We offer several different programs, each designed to support our members where they are, and we engage providers and community resources that will meet our members' specific health and SDoH needs. We urge CMS to continue to support such innovation, including through:

- **Expansion of Special Supplemental Benefits for the Chronically Ill (SSBCI) to Additional Populations:** SSBCI is a particularly meaningful tool for MA plans. By granting flexibility to offer primarily health related non-medical benefits, we can now address the social determinants of health that are directly impacting eligible beneficiaries' health outcomes. However, while this flexibility does allow plans to meet needs for non-medical supports and services for certain members, we are concerned that a substantial portion of our population cannot meet the definition of "chronically ill" despite needing non-medical supports. For example, many of our non-chronically ill members lack appropriate and accessible transportation, forcing them to miss or delay much needed medical care. The provision of non-emergency medical transportation (NEMT) would ensure those individuals could safely get to and from appointments. We, therefore, urge CMS to provide additional opportunities for MA organizations to expand when and how we offer targeted, non-medical benefits, such as NEMT, to additional populations.

- **Creation of a Nutritional Equity Model**: Nutritional equity is the foundation to achieving health equity. We urge the Centers for Medicare and Medicaid Innovation (CMMI) to use existing authority to launch a Nutritional Equity Model (NEM) that funds annual dietary pathway visits as well as facilitates access to medically tailored meals, medically tailored meal kits and/or medically tailored groceries. As part of the NEM, CMMI and USDA should coordinate to allow beneficiaries to voluntarily use their SNAP and other food benefits in the NEM model. We have attached a more detailed letter on this recommended initiative (see Appendix B).

- **Digital Therapeutics (DTx) Transparency Database**: Leveraging digital health could expand access but there are obstacles. Clinicians must be confident in a product's efficacy. The sheer number of digital products makes this challenging. While some are developed using rigorous methods, others lack rigor. Sifting through an ocean of products to find clinical "pearls" is laborious and inefficient for each provider or plan to expend resources to do so. CMS could develop a user-friendly DTx database where stakeholders could search by health condition to identify products with completed randomized controlled trials (RCT) as well as the specifics (e.g., size) and outcomes of the RCTs.

We appreciate this opportunity to provide input and hope for future collaboration. Please let us know if we can provide additional details regarding any of these recommendations.

Sincerely,

Christina Nyquist
Vice President, Federal Affairs
Point32Health

Point32Health

Appendix A:

Coalition Letter on 2018 RADV Proposed Rule, Submitted March 23, 2022

March 23, 2022

Meena Seshamani, MD
Director, Center for Medicare
Centers for Medicare & Medicaid Services

George Mills
Deputy Director, Center for Program Integrity
Centers for Medicare & Medicaid Services

Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Director Seshamani and Deputy Director Mills:

Thank you for meeting with us on February 17th. We are a diverse group of organizations from many regions across the country that collectively serve over 58 million Americans. Our common foundation is that we are not-for-profits that place our communities at the core of our mission. We are proud to serve Medicare beneficiaries with affordable products and innovative benefits.

We appreciate the time that you, your staff, and your colleagues spent with us in February. During our conversation, stakeholders raised several negative implications and issues regarding implementation of the 2018 Risk Adjustment Data Validation (RADV) proposed rule (2018 RADV Proposed Rule). This letter reiterates our concerns, which include:

- Negative implications with the 2018 RADV Proposed Rule: exacerbating health inequity; penalizing value-based care providers; and diminishing competition.
- Three specific problems in the 2018 RADV Proposed Rule: retroactivity, extrapolation, and lack of Medicare fee-for-service (FFS) Adjuster.

Furthermore, in the attached document, we include excerpts from letters submitted to the Centers for Medicare & Medicaid Services (CMS) by several not-for-profit organizations, provider groups, and other stakeholders. The purpose of these excerpts is to demonstrate that these issues were previously raised during the comment periods following publication of the 2018 RADV Proposed Rule.

We urge you to withdraw the 2018 RADV Proposed Rule and work with stakeholders on an alternative proposal that meets the needs of CMS and Medicare beneficiaries. Any future proposals should address concerns through targeted solutions that do not undermine the fundamental ability of the MA program to further advance health equity, transform health care from volume to value, and enhance the beneficiary experience.

Implications

If implemented, the 2018 Proposed Rule would:

1) **Exacerbate Health Inequity:** People of color would be disproportionately hurt by the proposed RADV rule for several reasons.

- First, underserved populations are more likely to choose Medicare Advantage (MA) because their adverse economic situations make the zero premium plans an imperative to access care without significant coinsurance and deductibles as well as critical supplemental benefits and coordinated care for chronic conditions. Nearly 50% of Black older adults and 54% of Latinx older adults are enrolled in Medicare Advantage. Overall, 33% of MA beneficiaries identify as a racial or ethnic minority compared to just 16% in traditional Medicare.
- Second, underserved populations are most likely to be served by providers in the communities where they live, many of which are small practices with limited resources that rely primarily on government programs. These providers often are not experienced in the complex coding and documentation practices needed to pass a RADV audit and have not had the resources and time to invest in understanding and implementing those practices.
- Third, people of color are more likely to have the health conditions that are inaccurately coded under the 2018 RADV Proposed Rule. For instance, coding around quadriplegia and amputations have higher coding error rates. African Americans with diabetes are 2.3 times more likely to have lower extremity amputations. African Americans also are more likely to suffer spinal cord injuries at almost double the rate of their population representation. Treating providers often fail to explicitly identify these conditions in the medical record because it may be presumed or readily apparent that the patient has the condition. Overall, Medicare Advantage has a 63% higher rate of beneficiaries enrolled in Medicare due to a disability.

For the reasons above, implementation of the 2018 RADV Proposed Rule would require health plans to make substantial investments in training providers and other RADV implementation related costs. This would be an enormous undertaking for regional not-for-profit health plans. This use of resources would of necessity shift health plan investments away from other projects that advance health equity.

2) **Penalize Value Based Care Providers:** Medicare Advantage Organizations (MAOs) utilize value-based contracts with many primary care providers and other clinicians. In many of these arrangements, most of any operating margins are delivered directly to the providers. As a result, if CMS attempts to retroactively recoup large sums, due to the extrapolation technique and lack of Fee For Service (FFS) adjuster from MAOs, many contracts between providers and health plans would require that the plans recoup the funds from the providers. This could financially destabilize provider practices and disproportionately impact vulnerable providers caring for underserved populations as well as primary care physicians.

3) **Diminish Competition by Destabilizing Not-for-Profit Health Plans:** Finalization of the 2018 RADV Proposed Rule would destabilize not-for-profit health plans and may even drive some out of the MA program. Not-for-profit plans simply lack the financial resources to withstand the instability that finalization of the RADV Proposed Rule would cause. In fact, for six of the years in the last decade (2011 to 2020), most not-for-profit health plans had margins that hovered *around or below zero*. This is exacerbated in plans that rely heavily on value-based payment arrangements because they are less likely to maintain operating margins as a cushion – as those are paid out to providers.

A vibrant marketplace should never be taken for granted. History demonstrates again and again that changes in state or federal regulations can rapidly change the scope of competition. For instance, in 2017 to 2019, many major insurers exited the Affordable Care Act (ACA) marketplaces. In many states, the continuity of exchange coverage was dependent on the fact that locally based not for profit companies remained. While many communities currently enjoy a wide variety of MA choices, consolidation already is increasingly occurring. The three largest MA plans now control 55% percent of the market – a significant change from 2015 when these three players controlled 46% of market.

Problematic Issues

The problematic outcomes described above are triggered primarily by three fundamental problems in the 2018 RADV Proposed Rule:

1) Retroactivity
2) Extrapolation
3) Lack of FFS Adjuster

These issues were highlighted in numerous letters submitted in the comment periods following publication of the 2018 RADV Proposed Rule. We continue to oppose these provisions. However, with the passage of time, our concerns with implementation are even more significant now. Today's health care system has changed from pre-pandemic times. Doctors and hospital staff were stretched to the breaking point during the pandemic and workforce issues continue to plague clinics. Insurers also faced significant challenges during COVID-19, and their employee teams worked taxing hours implementing last minute changes to meet the health needs of beneficiaries: rolling out expanded telehealth, adopting additional flexibilities for providers, conducting innovative outreach to increase vaccination rates, ensuring that home-bound members received necessary services and supplies and other critical issues. Many not-for-profit plans also have faced significant financial setbacks due to the pandemic.

In summary, we urge CMS to consider the substantive flaws we have raised with the 2018 RADV Proposed Rule from an actuarial, operational, and health policy perspective. We also ask CMS to recognize that now is not the time to inflict this rule on the health care system on which so many Medicare beneficiaries depend. We are proud that throughout this pandemic, our organizations have provided a critical partnership to CMS to enhance beneficiary care. We respectfully ask that CMS provide a similar level of flexibility and partnership in their efforts to modify the RADV system. Please contact us at Christina.Nyquist@Point32Health.org or Ryann Hill at RHill@ScanHealthPlan.com , if you would like additional information.

Thank you for your commitment to improving health care for older Americans.

Sincerely,

Alliance of Community Health Plans (ACHP)

Association for Community Affiliated Plans (ACAP)

Blue Cross Blue Shield of Massachusetts

BlueCross BlueShield of Minnesota

Blue Shield of California

Cambia Health Solutions

Fallon Health

Healthfirst

Point32Health, including Tufts Health Plan and Harvard Pilgrim HealthCare

SCAN Health Plan

Appendix:
Excerpts from 2018 and 2019 Comment Letters Support Key Concerns with 2018 RADV Proposed Rule

Italicized texts represent annotations linking current statistics to issues raised in comment period.

Below, we itemize specific sections of comment letters that support the six key issues we have raised with CMS. Specifically, implementation of the proposed RADV rule will:

I. Exacerbate Health Inequity

People of Color are more likely to have conditions that are subject to coding errors under the 2018 RADV Proposed Rule

- "If, as a result of the RADV audit, for example, certain lower cost enrollees no longer are considered diabetic but would have been considered diabetic in the FFS data used to develop the risk scores, then the payment for diabetic members in the payment year could be inadequate. In this example, the risk score factor associated with diabetes would be understated relative to the factor that would have resulted from using only substantiated diagnoses, because the lower cost patients would have lowered the average spending amounts among those identified as diabetics in the FFS data. When that factor is applied to similarly non-validated data, the total payments for those with diabetes would be adequate. When that same factor is applied only to those with substantiated data, however, the total payments could be too low. This type of data inconsistency not only creates uncertainty, it also may create systematic underpayment…potentially resulting in payment inequities….." (American Academy of Actuaries 1/21/2011, referenced again in 12/17/2018 letter)) -- *As the Office of Minority Health notes, African Americans are 60 percent more likely to have diabetes and twice as likely to die from diabetes, Hispanics are 70% more likely to have diabetes and 1.3 times more likely to perish from diabetes. Many minorities also have worse outcomes for other chronic conditions as well. Given that a disproportionate share of minorities depend on Medicare Advantage plans, these "payment inequities" will disproportionately hit Medicare beneficiaries of color.*
- "CMS' MA RADV approach gives no consideration to diagnostic-specific substantiation rates – an MA contract may have a higher prevalence of hard to substantiate diagnosis codes and therefore a high expected coding error rate. We strongly suggest CMS take such measures into account." (HealthfIrst 08/28/2019

- "Although the average discrepancy rate across the HCCs was 33.9%, some individual HCCs had rates at or near 100% (e.g., quadriplegia, other extensive paralysis; cystic fibrosis; amputation status, lower limb amputation complications) …" (FallonHealth 8/26/2019) *African Americans with diabetes are 2.3 times more likely to have lower extremity amputations. African Americans also are more likely to suffer spinal cord injuries at almost double the rate of their population representation.*
- "A fundamental tenet of the MA program is that plans and their members should be subject to uniform and even-handed treatment by CMS. This principle would be undermined by application of CMS's contract-level methodology, particularly as modified in the Proposed Rule." (FallonHealth 8/26/2019)
- "The purpose of RADV audits is to ensure the integrity and accuracy of risk adjustment payment data and to recover for unsubstantiated MA plan payments. However, this purpose is undermined by current rules that forbid appealing MA plans from including HCCs, medical records, or other documents beyond the audited HCC, the RADV-reviewed medical record, and any accompanying attestation. This rule imposes an arbitrary and onerous documentation standard that in no way furthers CMS's goal of properly assessing risk adjustment data. When an MA plan lacks a medical record that supports an audited HCC, CMS should allow the plan to adduce any evidentiary support demonstrating that the patient has the diagnosis in question. Such additional support could be found in Medicare Part D prescription drug data, laboratory results, prior or current claims data, or supplemental documentation from the patient's current treating physician attesting to the existence of the disease.

  This is especially important for certain chronic conditions that may require lifelong treatment, such as Parkinson's disease, Huntington's disease, aortic atherosclerosis, type 1 diabetes, or complications from an amputation. Treating providers often fail to explicitly identify these conditions in the medical record because it may be presumed or readily apparent that the patient has the condition. For example, if a beneficiary with type 1 diabetes is in the RADV sample, but the MA plan does not have medical record documentation from that year specifically establishing the condition, the plan should be able to furnish proof in the form of other claims data and/or prescription drug records for insulin. MA plans should be allowed (but not required) to provide alternative and supplemental forms of proof for an audited HCC under appeal to enhance CMS's ability to determine the accuracy of payment.

  On appeal, MA plans should be able to submit medical records from any date of service that supports the diagnosis of a chronic condition that cannot be cured. CMS has previously documented how physicians often do not report diagnoses for certain conditions in years subsequent to an initial diagnosis. A common example is Medicare beneficiaries with quadriplegia, where in one year, only 61% had a diagnosis of quadriplegia reported in the subsequent year. An MA plan may not be able to find a medical record in a particular year proving a diagnosis because, due to provider note practices, that record may not exist. But this diagnosis may exist in a medical record from a prior year reflecting a chronic disease that cannot be cured" (FallonHealth 8/26/2019)

  Research has demonstrated greater disability and disease severity in African Americans with Parkinson's than white individuals. There are also higher rates of Parkinson's dementia in African American and Hispanic populations. The prevalence of Type 1 Diabetes in Black and Hispanic

Seniors is more than double that of white seniors. As mentioned above, African Americans are 2.3 times as likely to have lower extremity amputations.

People of Color are disproportionately dependent on the zero premium and supplemental benefits offered by Medicare Advantage Plans. The 2018 RADV Proposed Rule would diminish the availability of these affordable plan options:

- "Centene also encourages CMS to consider the negative beneficiary impact the proposed policy may have; we are particularly concerned with the pricing dynamics that may occur…. Such organizations will not have the ability to spread costs across multiple contracts and thus may have to make more dramatic changes to their products and service areas to remain financially viable. [emphasis added]" (Centene 8/27/2019)
- "Finally, the increase in MA plan liabilities that would flow from retroactive application of the Proposed Rule's RADV methodology may deter MA program participation. Those plans that choose to participate will be forced to reserve a greater portion of their revenue to account for expanded and retroactively applied RADV audit liabilities. To accommodate these increased reserve needs, MA plans may be forced to:
    - Offer fewer supplemental benefits to enrollees;
    - Increase beneficiary cost-sharing obligations and premiums;
    - Dedicate fewer resources to the development of new value-based payment models;
    - Offer narrower networks; and
    - Offer fewer benefit packages for beneficiaries.

  (FallonHealth 8/26/2019)
- "BCBSA further notes that …CMS' proposed methodology…would, in turn, result in fewer rebate dollars, higher cost-sharing and premiums, as well as benefit reductions…. Thus, the ultimate harm stemming from the new methodology would impact not simply MA plans, but also their beneficiaries and the Medicare program as a whole." (BlueCross BlueShield Association)
- "The SNP Alliance is very concerned about this proposal and its potential harm to Special Needs Plans that, by definition, serve large numbers of high-risk members and often have smaller enrollments. We do not agree with CMS's proposed changes to the methodology. We believe this change could result in significant liability under RADV, which may impact the ability of plans to offer benefits that patients need, particularly the vulnerable beneficiaries of SNPs. [emphasis added]" (SNP Alliance 12/21/2018)
- "As a result of this phenomenon—which will undoubtedly occur industry-wide for MA plans that choose to continue participating in the MA program—a far greater number of MA plans will fail to qualify for CMS rebates. These MA plans will no longer be able to provide supplemental benefits, thereby negatively impacting MA beneficiaries." (FallonHealth 8/26/2019)
- "If implemented, these proposed changes would result in unintended and unwanted consequences for MA, beneficiaries and the Medicare program at large. More specifically, this change will result in inflated audit recoveries, which would distort bidding behavior in a number of ways that are detrimental to beneficiaries. For example, higher bids result in less ability to reduce beneficiary cost-sharing and expand supplemental benefits to address social determinants. (BlueCross BlueShield Association)

Financial resources available to Seniors of Color are significantly smaller than those available to White Seniors. Median retirement income of white individuals is $23, 292 versus only $16,863 for Blacks and $13,560 for Hispanics. The 2018 RADV Proposed Rule would make it harder to offer the zero premium plans that help this population those most. Furthermore, the RADV Proposed Rule could force health plans to change their service areas and underserved communities may be the most likely to be negatively impacted as a result of service area consolidation.

II. Penalize Value-Based Care Providers:

Numerous provider organizations expressed concerns that the 2018 RADV Proposed Rule would financially devastate primary care and other providers involved in value-based contracts.

- "In addition, systematic underpayments due to a flawed RADV methodology would result in slowed investments in value-based care arrangements due to systemic underpayments and an increased burden on providers serving MA beneficiaries." (BCBSA)
- "Brown & Toland Physicians provides accountable coordinated care through value based payment models to more than 330,000 HMO, PPO and ACO patients….We believe that MA is instrumental to the transformation of our national health care system from volume to value….we believe it is important that CMS know that elements of their newly proposed RADV and FFS policies will place undue burden on physicians….

  We oppose extrapolation [in the proposed RADV rule] based on Contract-Level RADV, which will have a significant negative and detrimental impact on provider groups and beneficiaries….We opposed the proposed method of recoupment of payments [under the RADV rule] which would indirectly result in unfairly low MA organization payments to providers. We oppose the elimination of the FFS adjuster due to the resulting premium increase or reduced benefits as well as concerns about the accuracy of [the] study…..We have also identified additional concerns with the 201 charts per MAO sampling size….implementing these findings down to the provider level may cause inaccurate results….

  The increased scope and number of RADVs is not sustainable for provider groups….Additionally, most provider groups are not operationally or contractually equipped to retract overpayments from individual physicians that they have contracted in a delegated model….Overall, primary care physicians are already greatly overwhelmed due to their increased patient panel size and documentation requirements, and we are concerned that contract level audits will lead to additional provider audits and therefore place heavy undue burden on them. This could ultimately result in a decrease in the continuity and quality of care for our seniors….We are concerned that contract level extrapolation and the recoupment of payments from MA organizations back to year 2011 would place undue financial burden on provider organizations. Further, health plans will seek these payments from the entire network essentially indiscriminately punishing providers without being able to target bad actors. This could result in significant negative consequences to meticulous organizations while feckless organizations may get away with minimal consequences." (Brown and Tolan Physicians 4/26/2019)

  Similar comments to the above were filed from providers in diverse regions from California, Texas, and New York.

- "I know the care that physicians like myself provide to MA patients, promotes population health and comprehensive services. This proposed CMS retroactive policy through extrapolation, going back to 2011 payment year, would be destabilizing to the care we as physicians provide to MA patients. Any return from the plans would be passed down to provider groups and ultimately our patients. This is contrary to public interest, and negatively impactful for the senior population we serve." (Submitted by Nine Different Primary Care Center Practices in California 12/17/2018)
- "In addition to the concerns mentioned above, the proposed changes would adversely affect care groups participating in shared risk arrangements with payers. A RADV sample size of 201, or less if the plan membership is small, isn't guaranteed to be statistically valid at the plan level and almost certainly wouldn't be if plan operations tie results back to care groups through small sample size attributed patient populations. The potential downstream effects of extrapolating payment error rates, and the resulting inequitable results, could undo years of progressive contracting partnership between payers and providers. Furthermore, any extrapolation of errors on the plan results will almost certainly cause additional prospective chart review of contracted providers. The additional staffing needs and overall resulting financial implications for care groups could be serious, and would likely be inaccurate due to statistical variance." – (HealthPartners 8/28/2019)

III. Diminish Health Plan Competition and Destabilize Not for Profit Plans:

Numerous comment letters raised concerns that the RADV Proposed Rule would reduce plan participation and disproportionately hurt small plans.

- "Inflated audit recoveries [under the proposed RADV rule] also discourage plan participation, deterring new entrants and constraining choice for beneficiaries…. Finally, the increase in MA plan liabilities that would flow from the Proposed Rule's RADV methodology may deter future MA program participation. Those plans that choose to participate will be forced to reserve a greater portion of their revenue to account for expanded and retroactively-applied RADV audit liabilities." (BCBSA 8/28/2019)
- "We feel [the RADV methodology] is flawed and that CMS has not adequately proven the accuracy of this methodology or the potential impact of this methodology on small plans….Moreover, this proposed methodology will have a disproportionate impact on smaller, not for profit D-SNPs who are less financially able to pay inaccurately high audit payments." (ACAP 12/28/2018)
- "Centene also encourages CMS to consider the negative beneficiary impact the proposed policy may have; we are particularly concerned with the pricing dynamics that may occur when a contract that is the majority or represents the entire book of MA business of an organization, is audited. Such organizations will not have the ability to spread costs across multiple contracts and thus may have to make more dramatic changes to their products and service areas to remain financially viable. Because of this, the policy as written could have the unintended consequence of driving toward further MA market consolidation among those organizations able to spread larger financial risks." (Centene 08.27/2019)
- "The methodology inevitably produces penalty outcomes that vary dramatically based on factors unrelated to coding accuracy, <u>such as contract size</u>, risk profile, and even chance." (FallonHealth 8/26/2019)

Not-for-profit health plans are more likely to have smaller contract sizes, and therefore would be more vulnerable to the problems with the proposed RADV methodology.

IV. Utilize Actuarially Inappropriate Extrapolation:

- "CMS RADV payment error extrapolation approach is prone to risk of inequitable treatment of contracts due to the randomness in CMS' sampling methodology. This randomness can be further exacerbated by variation in enrollment size, HCC mix, and absolute risk score, independent of coding accuracy. This can expose MA plans to significant financial risk based not on coding accuracy but rather on the volatility of the CMS RADV payment error calculation methodology, which if implemented, can lead to perverse incentives to plans to offset these measures." (Healthfirst 08/28/2019)

In addition, the comments expressing concern about diminished health equity, penalization of value-based care providers and reduced competition frequently point to extrapolation as a driving factor.

V. Impose Unreasonable Retroactivity

- "In addition, the SNP Alliance opposes applying this approach retrospectively to 2011 as proposed. While the overall impact of the new CMS RADV proposals is estimated to be less than one half of one percent of total MA annual revenue, the impact on individual contracts selected for RADV would be much more significant, particularly on those with smaller high-risk populations such as SNPs that would be unfairly forced into additional compliance activities to avoid negative audit results." (SNP Alliance 12/21 2018)

In addition, the comments expressing concern about diminished health equity, penalization of value-based care providers and reduced competition also frequently point to retroactivity as a driving factor.

VI. Create Unequal Standards on Medicare Advantage Plans: (FFS Adjuster):

- "Independent analysis completed by Wakely and others suggests that there is a baseline bias in FFS claims which should be considered when assessing risk adjustment payments." (Healthfirst 08/28/2019)
- "We believe that the newest CMS study [regarding FFS risk adjuster] is flawed and not reflective of the intent of the original rule, comparing the documentation difference between FFS and MA. We also believe that the database has several biases including that claims submitted for a given beneficiary are random and uncorrelated events. CMS's decision to eliminate the FFS Adjuster may reduce funding from CMS, either increasing member premiums or reducing member benefits…We would like to bring to your attention the high level of burden that the low (almost perfect) margin of error allowed for MA organizations as well as the burden CMS auditing places on providers. We would kindly ask that you consider allowing more leniency in the process for the benefit of our hardworking primary care physicians their patients." (Brown and Toland Physicians 4/26/2019) *Similar comments were submitted by providers across the country including Texas, California and New York.*

In addition, the comments expressing concern about diminished health equity, penalization of value-based care providers and reduced competition frequently point to the lack of a Fee For Service Adjuster as a driving factor.

Point32Health

Appendix B:

Nutritional Equity Model

Point32Health
1 Wellness Way
Canton, MA 02021
point32health.org

Point32Health

Ambassador Susan Rice
Director of the Domestic Policy Council
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Ambassador Rice,

Thank you for convening the upcoming conference on Hunger, Nutrition and Health. We applaud the listening sessions you have conducted and appreciated the opportunity to participate in your June 9th discussion. We were inspired when facilitators in that session specifically solicited "bold" ideas to address hunger, nutrition, and health.

In that spirit, we are writing with a specific proposal to address the White House Conference's Pillar #2: Integrate Nutrition and Health. Health equity is critical to overall societal equity, but achievement of a *future* with health equity requires us to achieve nutritional equity *now*. We believe this is the time for bold proposals.

Our Family of Companies

The Point32Health family of companies includes Tufts Health Plan and Harvard Pilgrim Health Care. Our health plans cover 2.2 million members across New England, including Connecticut, Maine, Massachusetts, New Hampshire, and Rhode Island. We offer all lines of health coverage, including Medicare, Medicaid, and commercial plans. We cover individuals dually eligible for Medicare and Medicaid as well as those purchasing coverage through subsidized ACA marketplaces.

Our family also includes Health Plans, Inc. (HPI), TrestleTree, and MedWatch. HPI offers an integrated population health solution – AchieveHealth – that incorporates proven interventions to mitigate cost drivers, control emerging health risks, and influence specific behavior patterns, while improving health and engaging members in meaningful ways. TrestleTree has had groundbreaking success in motivational change therapy in individuals with needs as diverse as those with opioid addiction and others with chronic diseases requiring weight loss or specific dietary regimens. MedWatch includes a proprietary IT infrastructure that facilitates communications to help patients successfully navigate the full continuum of care.

We are proud that Point32Health was recently recognized as one of the 50 most community-minded companies in the nation by Points of Light, the world's largest nonprofit dedicated to volunteer service. In prioritizing good corporate citizenship, Point32Health carries on the tradition of our heritage companies – Harvard Pilgrim Health Care and Tufts Health Plan. We work to improve community health and wellbeing for everyone. Our 2021 giving included $16 million to nonprofit organizations—through grants, sponsorships, matching gifts, in-kind donations, and other contributions:

- $7.4 million in Foundation grants to 200+ community organizations
- $2.3 million to local nonprofits through our match and mini-grant programs
- 5,000+ employee volunteer hours

Point32Health

Our Point32Health Foundation— newly formed through the combination of Harvard Pilgrim Health Care Foundation and Tufts Health Plan Foundation—supports organizations working to improve access to healthy, affordable food.

Advancing Food Equity

Eliminating barriers to healthy food access has long been at the center of our philanthropic work. Our Foundation supports changes to policy and practice that eliminate systemic barriers while also funding programs that produce and distribute fresh healthy food. We've provided grant funding to organizations working to make it easier to access SNAP benefits, supported the development of a food distribution serving seven towns lacking access to nutritious food, funded year-round mobile markets that bring fresh produce to eight underserved communities, and invested in a community-run supermarket to improve the availability of affordable, nutritious, culturally aligned food. In 2021, our Healthy Food Fund supported 33 programs serving 246 communities with 685 food distributions sites.

We also understand that systemic change often requires more than philanthropy. This year, we are interested in carrying this message to Washington DC to advocate for policy changes at the federal level that will improve nutritional equity across the country.

Our proposal for the White House Conference is comprised of the following:

1) **Create a pathway to healthy eating:** As a first step to a healthier life, it is important that vulnerable individuals – like Medicaid enrollees and low-income Medicare beneficiaries – know what their optimal dietary pathway is. Many patients are still told that type 2 diabetes is a life sentence. Many diabetics don't realize they can reverse diabetes – and even eliminate the need for insulin or other medications entirely – if they follow a certain prescribed diet. All Medicaid members should have an annual visit where they are "prescribed" a specific dietary pathway.
2) **Use existing authority to act now:** The Centers for Medicare and Medicaid Innovation (CMMI) – also known as the Innovation Center – has the authority to test new Medicare and Medicaid benefits without new legislative activity. Furthermore, if CMMI finds that a new benefit improves quality without increasing costs, it has the unilateral authority to make these benefits permanent and nationwide – without additional legislative authorization. Therefore, we propose that CMMI launch a new program – called the Nutritional Equity Model (NEM) – that funds annual dietary pathway visits as well as facilitates access to medically tailored meals, medically tailored meal kits and/or medically tailored groceries.
3) **Bundle federal resources:** Even prior to COVID-19, the federal government spent nearly $90 billion per year on food programs such as the Supplemental Nutrition Assistance Program (SNAP). As part of the Nutritional Equity Model (NEM), CMMI and USDA should coordinate to allow beneficiaries to voluntarily use their SNAP and other food benefits in the NEM model.
4) **Recognize the reality of modern family life:** Many individuals live in "mixed health status" families. Mom may be diabetic; her daughter may have celiac disease and her son may be a healthy teen boy. Meeting the distinct dietary needs of each family member is almost impossible to achieve today by piecing together SNAP benefits and other federal programs or charitable resources. 88% of SNAP recipients say they encounter obstacles to a healthy diet. 61% identify cost as an obstacle, 30% say it's the time needed for preparing meals while others identify other factors such as their lack of kitchen facilities, the distance to the store or their disability status.

   CMMI should use part of its $10 billion budget to fund Nutritional Equity Model (NEM) "plug and play" technology infrastructure that would facilitate the ability for beneficiaries to bundle their financial resources and seamlessly connect to culturally competent healthy food options. Picture the busy diabetic mother above able to log in once per week to her NEM account to address her

family's food needs for the entire week. The "mixed health status" family above may choose pre-made meals so that each member of the household can optimize their health. The app would display a variety of culturally competent meal options and allow for beneficiary choice.

Another family – with consistent dietary needs (e.g. diabetes reversal diet) – may choose the medically tailored groceries (MTG) option from the NEM program app. As part of the MTG pathway, the app would display a selection of recipe options consistent with a diabetes reversal diet. Once the beneficiary chooses the preferred recipes for the week, the associated groceries would auto-populate and be available for pick-up or delivery. NEM also would facilitate the acquisition of snacks and staples consistent with the dietary pathway.

The NEM program would be designed so beneficiaries could have 100% of their daily nutritional requirements met for the equivalent of the maximum SNAP monthly benefit. In return, beneficiaries would voluntarily use their SNAP benefit. Other sources would fund the difference to cover the real cost of a complete nutritional pathway (e.g. Medicare, other food programs, etc.)

5) **Outreach, educate and measure:** As participants in the NEM model, health plans would assure their members have access to culturally competent healthy food options reflecting the needs and composition of their local communities. Health plans would engage community advisory panels to develop appropriate comfort food availability for each dietary pathway and continuously survey participants on the quality and satisfaction with food options. Health plans would select the organizations allowed to offer medially tailored meal and grocery options through the NEM program, and assure these entities meet requirements for nutritional expertise, quality, cultural relevance, and community commitment.

   Health plans would educate members, providers and community-based organizations about the new program and the importance of various dietary pathways. Data algorithms would be used to identify beneficiaries who may benefit the most from the program. As part of an onboarding process, health plans also would identify if members needed additional infrastructure (e.g. microwave) and problem solve so members could effectively utilize the NEM program.

   Health plans also would collect and synthesize claims and other data to determine if individuals following a dietary pathway had improved health outcomes or decreased costs – so CMMI would have the data necessary to make a final determination regarding the expansion and permanence of the NEM program.

Solving nutritional equity is not simple. However, it is imperative if we are to achieve health equity. President Kennedy famously said, "We choose to go to the moon in this decade and do the other things not because they are easy, but because they are hard. Because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we're willing to accept."

Establishing a Nutritional Equity Model will test the ability of USDA and CMMI to step out of their siloes, for health plans to partner with food purveyors, and for citizens to embark upon a journey for the common good. Will it be challenging? Yes. Can it be done? Definitely.

We expect the NEM model would lead to a future where the following are no longer true:

1) Obesity prevalence among Hispanic children (25.6%) and Black children (24.2%)
2) African American diabetics are:
   - 2.3 times as likely to suffer amputations
   - 3.2 times as likely to develop End Stage Renal Disease

- 2.1x more likely to die from diabetes

By leveraging existing federal food funding, we also believe NEM will not increase federal spending and thereby would qualify to be made permanent and applied nationally. Please let us know if you have any questions, we can provide additional details upon request.

Sincerely,

Cain A. Hayes
President & CEO