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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services,
Attention: CMS-4207-NC
P.O. Box 8013
Baltimore, MD 21244–8013

May 29, 2024

Re: Medicare Program; Request for Information on Medicare Advantage Data (CMS-4207-NC)

Dear Administrator Brooks-LaSure;

The Robert J. Margolis, MD Institute for Health Policy at Duke University (Duke-Margolis Institute) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS or the Agency) request for information (RFI) on Medicare Advantage (MA) Data. The RFI provides an opportunity to build on CMS' continued work to engage with stakeholders and on opportunities to asses and strengthen MA. In particular, opportunities to enhance data capabilities in MA, building off stakeholder feedback on a 2022 RFI on various aspects of MA, including the availability of comprehensive, high-quality data and promoting transparency through public releases of MA data, all of which are important given the continued growth in MA and comporting steps the Agency is taking to modernize its research data assets. Our comments aim to build off our response to the 2022 RFI, focusing on opportunities to improve access to MA data and highlighting areas where additional data can support the provision of higher quality, more person-centered care to MA beneficiaries.

About the Duke-Margolis Institute

Established with a founding gift through the Robert and Lisa Margolis Family Foundation, the Duke-Margolis Institute aims to generate and analyze evidence across health policy and practice to support the triple aim of health care–improving the experience of care, the health of populations, and reducing per capita cost. The Duke-Margolis Institute's activities reflect its broad multidisciplinary capabilities, fueled by Duke University's entrepreneurial culture. It is a university-wide program with staff and offices in both Durham, North Carolina, and Washington, DC, and collaborates with experts on health care policy and practice from across the country and around the world.

The mission of the Duke-Margolis Institute is to improve health and the value of health care through practical, innovative, and evidence-based policy solutions. The Institute's work includes identifying effective delivery and payment reform approaches that support the transition to value-based care and collaborating with expert stakeholders to identify pathways to increase the value of biomedical innovation to patients – both through better health outcomes and lower overall health care spending.

As noted in our recent response to CMS' request for information on research data, Duke-Margolis's evidence generation strategy relies on our quantitative expertise, leveraging a range of health-related datasets through a variety of mechanisms. Duke-Margolis and University-wide faculty and staff have extensive experience in analyzing data to develop practical policy solutions and insights into CMS' programs. Indeed, use of Medicare data by researchers, health care organizations, and others plays a vital role in improving and transforming our delivery system. As such, we understand the importance of ensuring data are valid, reliable, and actionable and can address the most pressing policy and reform questions and needs.

Introduction

We appreciate CMS' continued commitment to the 2030 accountable care goal of 100% of Traditional Medicare (TM) beneficiaries in accountable care arrangements. MA plans are also well-positioned to be leaders in payment reform and the charge towards accountable care. This is especially true as the majority of beneficiaries now receive care through MA plans. Additionally, from the Health Care Payment Learning and Action Network (HCP-LAN), close to 58% of MA payments are attributed to Alternative Payment Models (APMs), demonstrating a continued investment among MA plans in value-based payment arrangements to improve care for beneficiaries. Notably, the HCP-LAN survey has consistently found that MA is the segment of the payment system is most likely to implement value-based payment arrangements, which can support the provision of coordinated, whole-person care. Additionally, specific feature of MA, including the ability for MA plans to provide supplemental benefits, such as in-home support services, nutrition supports, or transportation, also highlight MA's role in providing comprehensive, whole-person care for Medicare beneficiaries. Access to comprehensive data on the implementation of value-based payment arrangements in MA and utilization of program features is critical for supporting these efforts. The opportunity for MA to continue to be a leader in adoption of value-based payment arrangements and related care delivery reforms, coupled with the fact that MA now covers the majority of Medicare beneficiaries, underscores a need for modernized access to relevant data, to promote transparency and advance quality care and better outcomes for Medicare beneficiaries.

As MA penetration continues to grow, addressing the gaps in what we know about MA plans' performance in improving quality, patient experience, and affordability has become more critical. This includes understanding the types of APMs being implemented, the utilization of additional benefits, and how these approaches align with broader efforts to improve care across the health care system – including in TM, commercial payment arrangements, and Medicaid. Increased access to accurate and complete MA data can help advance effective implementation of MA plans and promote access to coordinated, whole-person care for beneficiaries.

We acknowledge that increased access to data to inform what we know about how MA plans are being implemented must be balanced against the burden of additional data collection. Efforts to strengthen MA data should leverage existing data systems used to inform care delivery and not impose additional administrative requirements or use separate reporting systems. It is critical that data collection is efficient and the benefits outweigh costs, including costs associated with increased provider burden or utilization of segmented data sources. As CMS outlines in its National Quality Strategy, there is an opportunity to leverage more standardized electronic data used to support care delivery (e.g., patient-reported experience measures), and existing data systems to support efficiency. CMS has also taken recent administrative steps to develop electronic standards for such data, which (along with patient experience measures building off CAHPS measures) potentially provides an opportunity for more efficiency, transparency, and insights about the implementation of MA value-based payment arrangements and availability of benefits.

We also appreciate CMS' continued commitment to addressing transparency, including in the recent Contract Year 2025 MA and Part D Final Rule that included outreach requirements for MA plans to issue a "Mid-Year enrollee Notification of Unused Supplemental Benefits" in an effort to ensure beneficiaries are aware of the supplemental benefits available to them and address unmet needs. The robust information about scope of the benefit, cost-sharing, access instructions, and available network information required to be included in these outreach notifications can help support beneficiaries in transparent decision-making related to the cost and utilization of available benefits.

As the Agency continues to take steps to improve the quality and relevance of MA data, Duke-Margolis acknowledges that the publication of new and expanded MA data and other reforms to enhance data capabilities can be a burdensome endeavor for CMS and for health plans, which in turn may have consequences for beneficiaries and providers. We recommend that CMS build off of this RFI, and other recent efforts to promote researcher access to data, to implement and support a collaborative process with researchers and other key stakeholders and identify a path forward to enhance data capabilities in MA and continue to strengthen the program. Given that some changes to MA data may occur outside the usual rulemaking process, there is a clear opportunity for the Agency to engage stakeholders in a thoughtful and ongoing manner to identify areas for further alignment and analysis, and understand how reporting requirements have potentially resulted in systematic improvements and any unnecessary burden, as well as any implementation challenges.

Areas for Comment

In addition to information we submitted on a previous RFI focused on improving the value and affordability of MA for beneficiaries, much of our comments are informed by a range of research work at the Duke-Margolis Institute, all of which support actionable directions the Agency can take to increase MA data and transparency with the aim of enhancing patient-centered care for MA beneficiaries. These include the following examples:

- *Modernizing Medicare Risk Adjustment and Performance Measurement:* This recently released white paper provides an overview of the current challenges with the risk adjustment system and opportunities to modernize the system by leveraging increasingly standardized electronic data in the health records and other care management platforms, as CMS has begun to do for performance measurement.
- *Engaging Specialists in ACO Models:* In recognition of the increasing role of specialists in managing care across the patient journey, we released an article in *Health Affairs Forefront* that provides strategies to increase specialist engagement in ACO models and value-based payment

arrangements. One strategy we present to increase engagement is to provide data and facilitate data sharing for enhanced specialty and primary care coordination, as CMS has done via its shadow bundle strategy. As CMS launches new models, such as the multipayer Making Care Primary model, which aims to provide primary care providers with regional data on specialist performance to inform high-value referrals, we highlight how MA could provider similar data to accountable practices to inform a more comprehensive picture of specialist performance, and could advance the use of patient-reported outcome measures to improve care – and better understand plan performance.

- *Supporting Comprehensive, Longitudinal Care for MA Beneficiaries:* In a two-part set of articles in *Health Affairs Forefront*, we explore opportunities for how MA can support equitable, person-centered, and longitudinal care through scaling home-based care. First, we discuss recent congressional and regulatory changes that have enhanced beneficiary access to community supports and increasing market activity supporting home-based care through MA. Then we discuss opportunities to advance equitable and more seamless home-based care offerings and uptake in MA.
- *A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care:* To identify opportunities for multipayer alignment, including policy recommendations and an implementation path forward, we completed an environmental scan and a series of three stakeholder workshops with Medicaid agencies, commercial payers, employers, data organizations, and others to develop a framework for multipayer alignment. This framework includes opportunities for CMS value-based payment initiatives to align across payers

We provide more specific feedback on several of CMS' questions below.

In the RFI, CMS seeks feedback on all aspects of data related to the MA program. We focus our comments on several areas: data-related recommendations that impact beneficiary access to care, prior authorization and care denials, provider directories and network adequacy, cost and utilization of supplemental benefits, cost and quality outcomes related to value-based care arrangements and health equity, and opportunities for CMS to leverage private sector data.

Leveraging MA Data to Increase Beneficiary Access to Care

Accurate, timely, and relevant data are the foundation of evidence-based reforms in MA. Outlined below are several areas of opportunity to enhance data collection and transparency where more accurate, meaningful, and administratively feasible data collection may be possible to better understand and address opportunities to improve MA performance, supporting MA plans that are better able to deliver a more patient-centered health care experience for Medicare beneficiaries.

Prior authorization and utilization management

Utilization management strategies, including prior authorization, aim to ensure the medical necessity and appropriateness of health care. An overall lack of transparency on why certain services are denied and limited data on the implications of prior authorization decisions on care outcomes (e.g., the length of time it takes for a beneficiary to receive care after a provider prescribes/orders a service), makes it difficult to determine whether the utilization management strategies plans utilize are working effectively and improve beneficiary care.

CMS has acted to address these challenges through recent rulemaking, with, for instance, requiring Medicare Advantage Organizations (MAOs) to send notices to providers accompanied by a reason for a denial when they make a prior authorization decision. CMS also updated guidance to shorten decision timeframes for standard prior authorization requests from 14 days to 7 days and 72 hours for expedited requests. These changes are to take effect in 2026. While MAOs prepare to implement these prior authorization decision notices and shortened decision timeframes, CMS should consider ways to leverage the resulting data and beneficiary experience measures related to such processes to assess progress in improving compliance with updated prior authorization requirements and enhance beneficiary access to care. Finding ways to make these data more easily accessible to researchers, providers, and beneficiaries will both enable insights about whether these new requirements are improving performance, and provide a better basis for identifying MA plans that are performing better. Additionally, CMS could examine MAO adherence to prior authorization requirements and denial rates against access-related questions in beneficiary experience surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to ensure new requirements are working as intended to increase beneficiary access to care.

There is also concern with the growing use of algorithm-informed prior authorization decisions. This has the potential to result in unintended consequences such as denied or delayed care due to algorithmic bias and the lack of clinical expertise. One approach to enhance transparency is to require MAOs to report on certain outcomes associated with algorithm-based decisions such as data on approvals and denials of a service as well as the rate of reversed decisions after an appeal. CMS could also build off of recent rulemaking by the Office of the National Coordinator for Health Information Technology (ONC) regarding updated transparency requirements and data inputs for decision support interventions.

Provider directories & network adequacy

A key difference between MA and TM is the use of provider networks in MA plans. To adequately meet beneficiary needs, beneficiaries and their clinicians need accurate information on providers available to deliver care in their health plan options. There is opportunity to enhance beneficiary access by ensuring provider directories are accurate and updated in a timely manner. CMS could advance these efforts by supporting plans and providers to reduce the administrative burden of updating provider directories.

Another opportunity is to increase transparency of network adequacy standards, ensuring they account for the full MA population as well as new care modalities (e.g., telehealth). One cohort of note is high-need MA enrollees such as individuals with complex health and social needs who struggle to access care in traditional settings and live in the community. This population of homebound or home-limited MA beneficiaries require a network of providers not currently captured in network adequacy requirements, and the demand will intensify with an increasingly aging population. Traditionally, network adequacy standards have been based on whether there are sufficient providers in a geographic region (measured by distance or beneficiary travel time to the provider). However, such a methodology assumes that a beneficiary is able to access their provider in a brick-and-mortar care setting. There is need for CMS to establish efficient processes of gathering reliable data from beneficiaries about their care needs (e.g., data on functional status) and experience accessing needed care (such as through home-based care) outside of normal rulemaking, which could be part of the collaborative process as described above. The collection and publication of this additional data would inform research on network adequacy and the accuracy of provider directories across MA plans.

Supplemental benefit cost and utilization

As discussed in our article on MA supplemental benefits, Congress and CMS established multiple new authorities in recent years through which MA plans can offer supplemental benefits – services provided by MA plans that are not supported through TM. As supplemental benefit offerings continue to grow, there is need to enhance data and transparency on supplemental benefit offerings and utilization. More comprehensive data will not only enhance beneficiary decision-making but also serves to improve the MA program. Key data that would be valuable to inform future policies advancing the beneficiary care experience include:

- What specific supplemental benefits are offered and to what degree. For example, MA plans do not specify the specific item or service provided in their plan benefit packages (PBPs) under a category (e.g., in-home supports services).
- Utilization data for MA enrollee use of supplemental benefits. Although there is growth in supplemental benefit offerings, a MA plan offering a service does not equate to beneficiary access and utilization. The GAO notes challenges with reporting supplemental benefits in encounter data due to the lack of appropriate procedure codes. Because health plans presumably have mechanisms to track when such benefits are used, CMS should explore administratively straightforward ways of capturing data related to benefit utilization.
- Quality and beneficiary experience data related to supplemental benefits.

We acknowledge CMS' continued efforts to increase data and transparency on MA supplemental benefits through recent rulemaking. Notably, CMS recently updated reporting requirements around Special Supplemental Benefits for the Chronically Ill (SSBCI), including requirements of plans to provide evidence that a benefit or service has a "reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee" as well as requiring that plans to document both denials and approvals of SSBCI eligibility. The CMS Innovation Center (CMMI) is also testing reporting requirements for VBID participants offering supplemental benefits in three priority areas – food and nutritional insecurity, transportation barriers, and access to general supports for living. CMS should work with stakeholders to assess the impact of these efforts to accurately and efficiently capture information on supplemental benefits and their use. These approaches can hopefully provide a foundation for efficient and informative reporting on supplemental benefits more broadly, fostering greater transparency and accountability in the MA program and ultimately leading to improved health outcomes for beneficiaries.

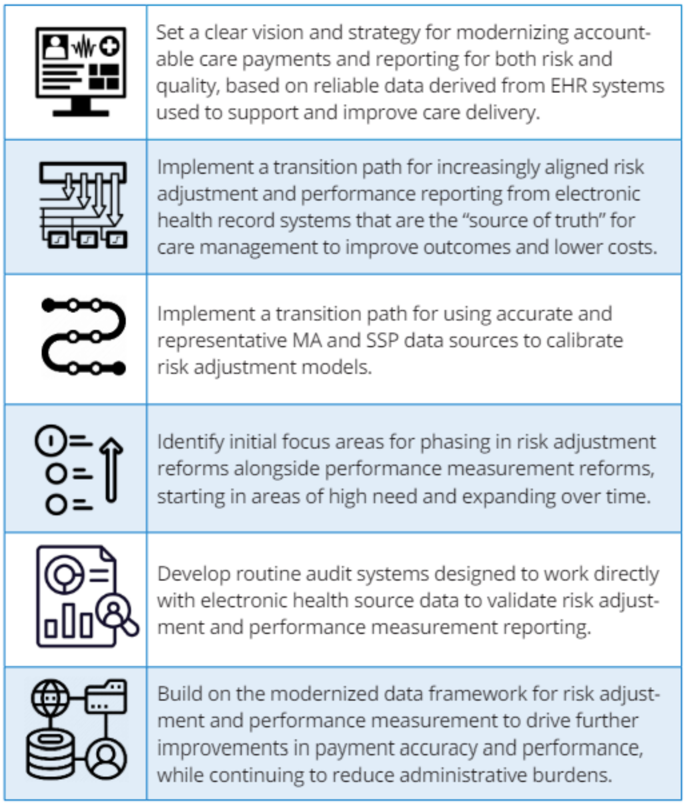
Opportunities to Increase Affordability and Sustainability in MA and Improve Quality Outcomes in MA Value-based Payment Arrangements

The increase in the number of providers participating in value-based payment arrangements across TM and MA presents an opportunity to align on and improve data availability on payment reform adoption across TM and MA. Work to date has highlighted the challenges facing the delivery system due to the lack of alignment of APM arrangements across payers. As efforts to increase multipayer alignment continue, measuring progress on directional alignment and standards across key value-based payment design elements (key payment reform features, quality measures, data sharing, and technical assistance) should be priorities. Efforts should focus on areas where lack of standards add to provider and plan contracting burdens, and complicate efforts to assess and compare plan and provider performance. Outlined below are several areas of opportunity for increased data alignment across TM and MA and improved transparency in MA to support affordability and sustainability of the program and the continued adoption of value-based payment among MA plans.

Risk adjustment

As discussed in our recent white paper on modernizing Medicare risk adjustment and performance measurement, the increasing number of beneficiaries in TM and MA in value-based payment arrangements presents an opportunity to modernize the current risk adjustment system to reflect this shift in the health care delivery system away from a fee-for service (FFS), claims-based system by leveraging data more reflective of value-based care models. These efforts reflect increasing standardization and secure data-sharing among providers and plans, specifically building on opportunities to reduce clinician and plan burden by relying on data that can be directly captured from EHRs, as CMS has already outlined in its foundational strategy for quality measurement. In its recent white paper, the Duke-Margolis Institute offered a variety of recommendations to facilitate these efforts:

Table 1: Proposed Steps for Modernizing Risk Adjustment and Performance Measurement



Set a clear vision and strategy for modernizing accountable care payments and reporting for both risk and quality, based on reliable data derived from EHR systems used to support and improve care delivery.
Implement a transition path for increasingly aligned risk adjustment and performance reporting from electronic health record systems that are the "source of truth" for care management to improve outcomes and lower costs.
Implement a transition path for using accurate and representative MA and SSP data sources to calibrate risk adjustment models.
Identify initial focus areas for phasing in risk adjustment reforms alongside performance measurement reforms, starting in areas of high need and expanding over time.
Develop routine audit systems designed to work directly with electronic health source data to validate risk adjustment and performance measurement reporting.
Build on the modernized data framework for risk adjustment and performance measurement to drive further improvements in payment accuracy and performance, while continuing to reduce administrative burdens.

These steps can enable progress not only in accurate risk adjustment, but also improving MA data accuracy and completeness for understanding MA performance. Specifically, by facilitating use of data already collected for key aspects of care delivery in EHRs, including data on key patient risk factors and potentially patient-generated data and social and economic data that are not reliably captured in claims or encounter data, the Agency can develop more accurate information on patient risk. Richer clinical data sources could also help identify less burdensome and more accurate ways to assure that those diagnoses are clinically meaningful, as well as help identify alignment opportunities across CMS' programs.

Improved Transparency in MA to Support Value-based Payment Adoption & Multipayer Alignment

Improved transparency through access to additional data on MA APMs is critical to understanding how value-based payment arrangements are being implemented by MA plans and providers, in addition to identification of opportunities for multipayer alignment across payers. There are a number of opportunities to support increased transparency and value-based payment adoption in MA, including: measure and data system alignment across standard data sources, availability of plan or contract-level data on APM adoption, publication of specialty performance data to encourage specialist participation in value-based payment arrangements, alignment on the collection of data to advance health equity, and broader alignment on data collection and quality reporting metrics to reduce burden and streamline across programs.

Leveraging Existing Data to Measure the Whole-person Care Experience

As we outlined above and in our white paper on modernizing risk adjustment and performance measurement, there is an opportunity to leverage data that exists within EHRs, disease registries, and other care management platforms, including those managed by plans that provide care management services, to gain insights into the care most Medicare beneficiaries are receiving, but currently not reflected in encounter data or FFS claims. As outlined in CMS' quality strategy, the use of standard EHR data across programs focused on the comprehensive care experience, including interactions with care team members, care coordination touch points, virtual care visits, and additional patient experience measures can support an aligned data collection strategy reflective of beneficiary care experiences and reduce reporting burden for providers and plans. We encourage CMS to build off existing data used to inform care delivery, including patient-reported measures that assess provision of person-centered care (e.g., CAHPS).One opportunity may be to identify high-burden diseases that driven significant expenditures in the Medicare program and pilot a data collection effort whereby CMS can, through the collaborative process described above, identify meaningful data elements that can be standardized, collected, and analyzed to develop programmatic insights into MA. This would avoid unnecessary burden and ensure only relevant care information is collected, while also ensuring health care organizations, researchers, and other stakeholders have access to richer data. For example, CMS could identify quality performance and care information that pertains to improving hemoglobin A1c control by collecting lab values, patient reported outcomes, and other information (dietary education, data from health-related social screenings, etc.) from these platforms into datasets. Specifically, these data elements could then be future standardized via bulk FHIR definitions with minimal data burden and then incorporated into data for researchers. This could be replicated across multiple different conditions.

Increased Transparency in Plan-level APM Adoption

There is limited evidence to date to understand how aligned MA APMs are and their effectiveness at reducing costs, improving care, and achieving better population health in the MA market. Specifically, there are existing gaps in the publication of certain MA data, including reporting plan payments to providers. Currently, CMS collects but does not publish payment information for MA plans, including payment amounts or type of payment made to a provider (e.g., capitated or FFS). Without this information, it is difficult to assess quality of care and how MA plans allocate resources compared to TM. Specific reforms could include CMS publication of additional data and summary information for public use so researchers can assess how APMs are improving the MA market, as the release of additional data on provider-level payments could inform how specific payment arrangements are being implemented on the ground.

There is an opportunity for CMS to release more specific data on MA plan or contract-level use of APMs to understand what types of payment reforms plans are undertaking. As we highlight in previous research, access to these data could inform general trends on uptake of different value-based payment models under the HCP-LAN APM Framework, and provide a regular source of information about the types of APMs MA plans have implemented. The provision of this data would not entail sharing propriety information such as contract details, which is a concern of many plans. This information is already reported at the aggregate level, through the HCP-LAN annual measurement survey, which reports on the aggregate percentage of APM utilization across the APM Framework categories. Access to information on payment reforms being implemented by MA plans at the individual plan or contract level would allow researchers to identify and evaluate which policy options (e.g., current legislative proposals about APM bonus reform) focused on MA payment reforms are most effective at incentivizing APM adoption among MA plans. Access to additional data on APM adoption at the contract level can support CMS' broader goals for whole-person care reform, including the 2030 accountable care goals.

Better Data Related to Specialty Performance

There are specific data elements that would be beneficial to supporting the acceleration of accountable care that could be applied consistently to MA as well. For example, as CMMI has outlined in its specialty care strategy, a critical element to reducing care fragmentation and moving towards whole-person, accountable care is increased access to coordinated and integrated specialty care. A number of efforts have been undertaken in TM to support specialist participation in accountable care models and high-value referrals between primary and specialty care providers. Notably, earlier this year CMMI began providing shadow bundle data on specialist performance related to major procedures and hospital-based short-term episodes to ACOs in SSP and ACO REACH, to inform their engagement with specialists.

However, such data are still in early stages of use, and focus primarily on acute episodes and interventions. Eventual efforts should expand to include measures of primary-specialty coordination in managing major chronic conditions including cardiovascular conditions (e.g., advanced congestive heart failure), musculoskeletal conditions (e.g., lower back pain and osteoarthritis), respiratory conditions (e.g., chronic obstructive pulmonary disease), and gastrointestinal conditions (e.g., inflammatory bowel disease), among others. CMS has made notable progress for ESRD and CKD, and the initial management of some important major cancers. To build on that progress, we encourage CMS to continue to work with private payers to identify priority areas for measure alignment, data-sharing opportunities, and other best practices. For example, as we outlined in a recent *Health Affairs Forefront* article, under the Making Care Primary model, primary care providers will be given access to regional data on specialist performance metrics (including detailed data on financial performance, utilization, and quality measures) to provide a more comprehensive view of specialist performance and inform high-value referrals. CMS could explore opportunities to work with MA plans in a similar capacity to support transparency in specialty performance metrics.

Standardized Collection of REL Data to Advance Health Equity

As part of its commitment to advance health equity, CMS has continued its efforts to accelerate collection of sociodemographic data, including race, ethnicity, and language (REL) data, and health-related social needs (HRSNs), also referred to as Social Determinants of Health (SDOH), data across value-based payment models and programs. For example, CMMI included requirements for the collection of voluntary beneficiary-reported sociodemographic data in the ACO REACH Program. A SDOH reporting requirement is also included in the REACH Program, and CMMI provides participants with a list of three SDOH screening tools to leverage for this data collection. We also acknowledge CMS' recent efforts to voluntarily collect race and ethnicity data on MA and Medicaid Part D enrollment forms. These efforts are a part of a broad CMS strategy to implement REL data standards across programs, including the release of an Inventory of Resources for Standardized Demographic and Language Data Collection earlier this year. As efforts to collect REL data and HRSNs data in TM continue, we recommend CMS support more efficient and effective ways of reliably collecting and using such data in the MA measurement process to align with REACH and other TM value-based payment arrangements. Accurate data will require improved strategies to communicate with beneficiaries to build trust about how data will be used and subsequent steps to incorporate data into care improvement models. Adequate collection of REL data across programs can support identification of disparities in quality of care and subsequent implementation of quality improvement interventions aimed at addressing these disparities.

Alignment Across Data Collection & Quality Reporting

As we highlight above, there are challenges associated with the lack of alignment in APM arrangements across payers, which creates additional burden for plans and providers, particularly for data and quality measurement standards. There is an opportunity for CMS to build incentives into MA to encourage plan participation in aligned multipayer models, rather than relying on similar but administratively inconsistent performance measures and data sharing. We acknowledge CMS' current alignment efforts, including implementation of the National Quality Strategy and a focus on interoperable, digital quality measures to reduce burden and allow for comparisons across programs. We encourage CMS to continue these multipayer alignment efforts and identify opportunities to eliminate differences in data and quality measurement standards for SSP, REACH, and other value-based payments models and MA to support increased adoption of APMs among MA plans.

Conclusion

The Duke-Margolis Institute appreciates CMS' consideration of our comments and the Administration's support for MA, including expanded access to data and multipayer alignment. As our health care delivery system continues to shift towards participation in value-based payment arrangements coupled with the continued increase in the number of Medicare beneficiaries in MA, strengthening the program and improving transparency to ensure access to services and equitable, whole-care is imperative. Please do not hesitate to reach out to us with additional questions.

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