May 29, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

Arnold Ventures welcomes the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the “Medicare Program; Request for Information on Medicare Advantage Data” (CMS-4207-NC) that was published in the Federal Register on January 30, 2024.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. We work to develop evidence to drive reform across a range of issues including health care, education, and criminal justice. Our work within the health care sector is driven by a recognition that the system costs too much and fails to adequately care for the people it serves. First, we want to thank the agency for its important work to help improve the Medicare Advantage and Prescription Drug Benefit programs. We recognize the high volume of comment letters that you will receive and the competing priorities you are facing and appreciate the opportunity to provide input.

We applaud CMS’s commitment to improving data transparency in Medicare Advantage, which is critical for appropriate oversight of the program. Medicare Advantage accounts for over half of all Medicare enrollment, up from around 30 percent a decade ago, and enrollment is projected to reach 60 percent by 2030.\(^1\) Medicare Advantage is also a major driver of overall Medicare spending, and the federal government pays about 22 percent more for beneficiaries enrolled in Medicare Advantage compared to similar beneficiaries in traditional Medicare – a difference that amounts to $83 billion in 2024.\(^2\)

Despite the size of the program and increased spending, data on Medicare Advantage are less available relative to data on traditional Medicare. Over the last several years, the Medicare Payment Advisory Commission (MedPAC) has emphasized that policymakers need better information on key aspects of the Medicare Advantage program to monitor program performance, evaluate payment policy, and assess quality of care and other aspects of the program.\(^3\) Given the number of beneficiaries enrolled in Medicare Advantage and its continued growth, it is now more important than ever for CMS to enhance data transparency in Medicare Advantage to ensure the program delivers value to the 30 million beneficiaries that rely on it.

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In the comments that follow, we lay out several recommendations that focus on 1) making certain data that are already collected today publicly available, 2) improving the accuracy of some of the data collected today, and 3) collecting new data to aid in program integrity efforts. We recognize that these recommendations, especially those focused on improving data accuracy and collecting new data, can be time consuming and costly to the agency. The agency may be required either to reallocate existing resources or need additional funding in order to make data available according to our recommendations. Despite this, we believe our recommendations are critical for improving the integrity of the MA program and the investments are therefore worthwhile.

Our comments focus on the following recommendations and more detail is provided below:

- Ensure that people are getting access to covered services through their Medicare Advantage plan;
- Collect and release data on ownership arrangements in the Medicare Advantage market and related party transactions to increase transparency;
- Continue to improve the encounter data, including by adding payment information;
- Continue to expand reporting requirements for use of supplemental benefits data;
- Make additional risk score data available to researchers to support research on overpayments due to upcoding;
- Enhance transparency around marketing of Medicare Advantage plans;
- Create more transparency and accountability for plans that serve people who are dually eligible for Medicare and Medicaid;
- Foster more transparency on state program design decisions for their dual-eligible population; and
- Collect and report data specific to Employer Group Waiver Plans (EGWPs)

Ensure that people are getting access to covered services through their Medicare Advantage plan

**Background:** CMS has historically collected very little information about the utilization management practices and administrative performance of Medicare Advantage plans (e.g., detailed prior authorization information, denials, appeals, etc.). While CMS recently finalized new requirements for Medicare Advantage organizations to publish summary data on the use and timeliness of prior authorization decisions, CMS does not require reporting of prior authorization requests, denials, and appeals by type of service or for specific plans. Additionally, a recent investigation and Senate probe have raised concerns that Medicare Advantage plans’ use of proprietary algorithms or other decision support tools for prior authorization determinations have resulted in inappropriate denials of care. Given ongoing concerns, there have been multiple calls to increase transparency around utilization management, and there is precedent for requiring such data to be made available.

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5 Ross, C. and Herman, B. *How Medicare Advantage plans use AI to cut off care for seniors*, STAT. March 2023.
very similarly to Medicare Advantage plans but serve the Medicaid population, are now required to provide information that is included in states’ Managed Care Program Annual Report (MCPAR) each year.\textsuperscript{9} States must report by plan information regarding appeals, grievances, and program integrity related concerns and post the data publicly, for example.

\textit{Recommendation:} CMS should begin collecting and reporting utilization management and certain administrative performance data at the plan level. We recommend CMS consider bringing the data collected into alignment with the information that states are required to report on MCPAR to the degree it makes sense. We also recommend that these data be delineated by people who only have access to Medicare coverage and those who are dually eligible for Medicare and Medicaid.

\textit{Justification:} The lack of utilization management and administrative performance data creates large gaps in our knowledge about how plans are operating with the taxpayer dollars that they receive to deliver the Medicare benefits, and whether people are actually able to access the benefits to which they are entitled. There are a significant number of reports that point to potential concerns about access, but little data to quantify the degree to which lack of access may be a problem in the Medicare Advantage program on a wide-scale basis. Furthermore, lack of transparency makes it difficult for CMS, researchers, and other stakeholders to track patterns of poor behavior amongst particular insurers and the extent to which these behaviors have implications for equity. For example, government investigations have found that disenrollment from Medicare Advantage can signal that certain plans are not providing access to high quality care and providers.\textsuperscript{11} Researchers can combine multiple CMS datafiles today to tell a more robust story of disenrollment data—however, publishing additional information on disenrollment in way that a broader group of stakeholders can use would enable better assessments of quality and access issues including whether disenrollment is higher for certain subpopulations such as people who are dually eligible for Medicare and Medicaid, racial/ethnic minorities, and high-need populations. Specific information that we recommend be reported in a format that is easy to use by both researchers and other stakeholders includes:\textsuperscript{12}

\begin{itemize}
  \item Detailed prior authorization data, including as it pertains to number of requests, approvals, denials, and justification by denial by general service categories and certain provider types;
  \item Disclosure of algorithms, technology, or other tools used to aid in prior authorization determinations and the services/items they are used for;
  \item Appeals and grievance data;
  \item Timely access to durable medical equipment;
  \item Additional disenrollment data including characteristics of beneficiaries who disenroll and reason for disenrollment; and
  \item Plan compliance information.
\end{itemize}

The dually eligible population experiences their Medicare coverage differently than people who are not dually eligible because of the overlapping benefits they receive due to being enrolled in two programs. For

\textsuperscript{9} Managed Care Program: State Responsibilities. \textit{42 C.F.R 438.66(e)}. May 2024.
\textsuperscript{10} Medicaid and CHIP Managed Care Reporting. Medicaid.gov.
\textsuperscript{11} U.S. Government Accountability Office. \textit{Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending (GAO-21-482)}. June 2021.
this reason, it is important to understand whether Medicare Advantage plan’s utilization management practices impact this population differently than their counterparts with Medicare-only coverage, which may impact a person’s ability to access care and states’ ability to assess plans for participating as a D-SNP in their state and hold plans that do operate D-SNPs accountable for outcomes. The ability of states to do these analyses is also a reason why creating alignment with the Medicaid managed care requirements to the greatest extent possible is ideal.

For this data to be of use though, it will have to be accurate. Therefore, CMS should not only collect this data but audit it. We recognize that this could create a significant burden for CMS and may require additional resources in order to be executed effectively. Our recommendation is that audits be conducted based on the risk of the contract and the identification of outliers to reduce the operational burden that conducting audits on a dataset of this nature could create.

Collect and release data on ownership arrangements in the Medicare Advantage market and related party transactions to increase transparency

Background: Vertical integration between Medicare Advantage insurers and physician practices is increasing, with several insurers having invested resources in acquiring physician practices over the last few years. This kind of consolidation has implications for the Medicare program and signals that Medicare Advantage plans see significant financial advantages to acquiring physician practices, some of which stem from Medicare Advantage payment policy. While vertical integration may enable more efficient care delivery, there is no clear evidence this is occurring. However, there is emerging evidence to suggest this kind of consolidation may have harmful effects that increase costs for the federal government and taxpayers. Oversight of the Medicare Advantage program has not kept pace with increasing consolidation in the market, and there is a lack of transparency around ownership arrangements which impedes our ability to understand the impact of vertical integration in Medicare Advantage and inform appropriate oversight.

Medicare Advantage plan acquisition of related businesses (i.e., physician practices, supplemental benefits providers) raises a few concerns. For example, evidence suggests that Medicare Advantage insurer acquisition of physician practices enables plans to engage in more intensive diagnostic coding to inflate their risk-adjusted payments, which increases costs to the Medicare program and taxpayers. Vertically integrated plans’ ability to engage in risk score gaming to inflate payments is likely a significant driver of this kind of consolidation in the Medicare Advantage market.

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14 Minemyer, P. Humana, Private Equity Firm Launch 2nd Primary Care Joint Venture. Fierce Healthcare. May 2022
Another concern supported by emerging evidence is that vertically integrated plans can evade medical loss ratio (MLR) rules intended to limit plan profits. (MLR regulations require plans to spend at least 85 percent of their premium revenue on patient care versus other items such as administrative expenses or profit.) Because related businesses are not subject to the MLR, parent companies can structure favorable intercompany financial arrangements that circumvent the MLR to maximize profits for the vertically integrated plan. For example, parent companies can direct their Medicare Advantage plan to purchase services from related businesses under the parent company at prices that exceed market-level prices, which side-steps MLR rules by increasing the amount of revenue spent on patient care while at the same time boosting the overall profitability of the parent company.19, 20

CMS requires that Medicare Advantage plans report arrangements with related businesses and document the effects on prices for paid services by comparing prices paid to what the prices would be without such arrangements; however, payments from related businesses to the parent company may still increase profitability while technically complying with MLR requirements, highlighting the need for more transparency and oversight of Medicare Advantage plans’ financial relationships with related businesses and updates to CMS regulatory framework.21

Recommendation: CMS has authority to require reporting of ownership and corporate structure data and should enhance ownership transparency in the Medicare Advantage market and across the health care sector more broadly. Within the context of Medicare Advantage, we encourage CMS to collect and release data on mergers and acquisitions between Medicare Advantage plans (including the parent companies) and physician practices with more than 25 physicians; physician practices owned by Medicare Advantage plans (including the parent companies) and changes in ownership. These data should be released annually. In addition, CMS should collect ownership information (e.g., name, corporate structure, tax status, etc.) about related third parties that may provide operational support or support with quality related activities that are owned by the reporting entity, and these third-party entities should also have a unique identifier that can be linked across various datasets.

Given evidence suggesting that parent companies can structure intercompany financial arrangements to circumvent the MLR and increase profitability, greater oversight is needed to hold parent companies more accountable to MLR requirements. A first step that the Administration could take to protect against MLR gaming is to improve the transparency of transfer prices for related business entities.22 Specifically, CMS should require parent companies to disclose transfer prices and subsidiaries to report actual costs for good and services, and CMS should release information on aggregate payments to related entities in Medicare Advantage plans’ bid data. For example, CMS could require payment information to be included in the encounter data (discussed more below). CMS should publish guidance, including disclosure requirements and how to appropriately determine charges between affiliated entities (e.g., between MA

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plans and related physician practices or home health companies) and the actual costs of affiliated entities. In addition, CMS should establish an approach for assessing whether transfer prices reflect reasonable market-level rates.²³

*Justification:* Enhanced ownership transparency can enable more appropriate oversight and regulation of the Medicare Advantage market to protect taxpayers and beneficiaries. If made available, these data can also help researchers and policy experts analyze emerging trends, highlight competition issues, and identify nuances to inform policy development. New data reporting requirements around plan costs when plans purchase goods and services from related entities owned by the same parent company (e.g., a Medicare Advantage carrier that owns and contracts with a home health provider) would provide greater transparency and accountability in Medicare Advantage. This information can help guide CMS in updating its regulatory framework and is an important first step in addressing Medicare Advantage plan tactics to circumvent MLR requirements intended to limit plan profits.

**Continue to improve the encounter data, including by adding payment information**

*Background:* All Medicare Advantage plans are required to report encounter data and it is increasingly being used for risk adjustment purposes. The quality of the data continues to improve as a result, and we expect this trend to continue so long as this data is increasingly tied to payment. However, there are still significant gaps in the encounter data and continued improvement is necessary.²⁴ Today, CMS collects payment data for each encounter that is paid for on a fee-for-service basis. This information is not made available to researchers, however. It is also our understanding that plans may omit any non-FFS payments (e.g., quality withholds and bonuses and any sub-capitated arrangement) to providers in the information they provide, thus even those with the payment level data cannot paint an accurate picture of total compensation to providers.

*Recommendation:* We urge CMS to continue to make improvements to ensure encounter data accuracy. In addition, make provider payment data available to researchers, and expand what is collected to include all payments made to providers today which should include sub-capitation and quality-related payments. This information should reflect an accurate depiction of what the provider was actually paid by the Medicare Advantage plan (i.e., account for patient sharing liability).

*Justification:* Improving encounter level data from Medicare Advantage plans is both necessary for understanding the care delivery patterns provided by these plans compared to traditional Medicare and for determining if Medicare Advantage plans’ payments to their provider networks are adequate. As more beneficiaries enroll in Medicare Advantage, it becomes even more important to understand these dynamics to ensure CMS is creating consistency as appropriate so it can reduce provider burden and ensure all people who enroll in Medicare are receiving high-quality care. Medicare Advantage plans must be held more accountable for the accuracy and completeness of the data they submit to CMS to enhance oversight and enable a better assessment of quality and value in Medicare Advantage.

We encourage CMS to contemplate developing a policy modeled after the process CMS uses to collect and assess data submitted by state Medicaid programs. This would entail 1) developing a set of measures that compare encounter data to external and plan-generated data sources to benchmark the accuracy and completeness of encounter data, and 2) implementing a small payment withhold that could be returned to plans based on how they perform on the accuracy and completeness measures. This recommendation is consistent with actions that the Government Accountability Office has urged CMS to adopt to verify if plan-submitted data are accurate including establishing benchmarks for completeness and accuracy and reviewing medical records to verify data. MedPAC has also made recommendations along these lines to enable CMS to obtain better information on the quality of care in Medicare Advantage, evaluate Medicare Advantage payments, and assess other aspects of the program.

Continue to expand reporting requirements for use of supplemental benefits data

*Background:* A key difference between traditional Medicare and Medicare Advantage is that Medicare Advantage plans can offer extra benefits such as vision, dental, and fitness benefits. There has been significant growth in supplemental benefit offerings over the last several years, although the scope and generosity of benefits offered varies. Moreover, rebate dollars, which plans use to fund extra benefits, are near historic highs, enabling plans to offer more generous benefits. Yet, at the same time, there has been little information available to date to assess the value of these extra benefits.

CMS has begun filling this gap by implementing a series of new reporting requirements on the use of supplemental benefits and some information on spending. The new data reporting requirements will enable CMS to assess the extent to which supplemental benefits are being used, whether there are variations in utilization based on key beneficiary and plan characteristics, the extent to which supplemental benefits can improve equity, and aggregate spending by category of benefit. While this information will be useful for beginning to ascertain the value of supplemental benefits, there remains a need for detailed

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31 *Agency Information Collection Activities: Proposed Collection; Comment Request.* Federal Register. March 2023.

payment and spending information to assess which specific benefits provide the greatest value to beneficiaries.\textsuperscript{33}

\textbf{Recommendation}: CMS should require Medicare Advantage plans to report detailed, disaggregated payment and spending information on supplemental benefits (e.g., payment for a dental visit), including patient liability. In addition, CMS should make data collected from new reporting requirements available to researchers as soon as possible.

\textbf{Justification}: Having detailed payment information along with data on utilization of supplemental benefits is necessary to assess the value of these benefits to beneficiaries and taxpayers. These data could be used to assess the extent to which these benefits are accessible to beneficiaries versus being used by Medicare Advantage plans as a marketing tool to drive enrollment. These data are also needed to better understand the connection between the use of supplemental benefits and beneficiary health outcomes which is an important aspect of assessing their overall value.

\textbf{Make additional risk score data available to researchers to support research on overpayments due to upcoding}

\textit{Background}: Under the current Medicare Advantage payment system, plans receive risk-adjusted payments based on coded diagnoses of their enrollees that are intended to account for differences in enrollee health status and expected costs. Research consistently shows that Medicare Advantage plans abuse the system by engaging in more intensive coding which makes their enrollees appear less healthy and inflates payments to plans.\textsuperscript{34, 35} In addition, an emerging concern is that vertically integrated Medicare Advantage organizations have greater coding intensity and may be better able to engage in upcoding.\textsuperscript{36, 37} This may be a driver of Medicare Advantage acquisition of physician practices but there is a need for more research to better understand this issue.\textsuperscript{38}

\textbf{Recommendation}: CMS should make existing beneficiary-level risk score data (including for additional and more recent years) available to researchers to enable more comprehensive assessments of Medicare Advantage plan upcoding to inflate payments.

\textbf{Justification}: While there is a substantial body of evidence that shows Medicare Advantage plans engage in upcoding to inflate payments, making additional risk score data available to all stakeholders will support more nuanced investigations into this issue to support evidence-based policymaking. For example,

beneficiary-level risk score data could be used to examine the extent to which there is greater upcoding among specific Medicare Advantage plans, which could inform CMS’ approach to addressing coding differences in Medicare Advantage (i.e., increasing the coding intensity adjustment via a tiered approach that targets the Medicare Advantage organizations that engage in the most upcoding). ³⁹

Enhance transparency around marketing of Medicare Advantage plans

Background: Selecting an insurance plan can be overwhelming for beneficiaries because of the variety of Medicare Advantage plans from which they can choose and insufficient information about the plans’ networks and providers. Beneficiaries are also subject to aggressive and misleading marketing tactics which may limit beneficiaries’ ability to make an informed decision about the health insurance option that works best for them.

Recommendation: CMS should continue to build upon recent regulations around Medicare Advantage marketing to protect beneficiaries from unsolicited contact from agents/brokers and misleading tactics. ⁴⁰, ⁴¹ Specifically, we suggest that CMS: (1) require marketers to disclose that plans have limited provider networks with fewer physicians and hospitals than traditional Medicare and that beneficiaries pay more if they go out-of-network for covered services; (2) expand the “effect on current coverage” section in the Pre-Enrollment Checklist so that beneficiaries are informed that they could be denied a Medigap policy should they switch to traditional Medicare after remaining in MA for more than one year; and (3) further limit the use of the Medicare name in private hotlines or non-government websites, which can confuse beneficiaries looking for 1-800-Medicare or Medicare.gov and represents a grey area in the CY 2024 Final Rule requirement prohibiting any misleading use of the Medicare name. ⁴² We also believe CMS should provide support for sources of accurate and unbiased information outside of commercial interests to meet beneficiary demands for assistance with choosing plans, like State Health Insurance Assistance Programs and the Senior Medicare Patrol, as recommended by the Senate Finance Committee. ⁴³

Justification: Improving the information available to beneficiaries when selecting Medicare coverage by limiting misleading tactics can help improve beneficiary decision making and hold plans more accountable.

Create more transparency and accountability for plans that serve people who are dually eligible for Medicare and Medicaid

Background: Today, most quality and financial data is collected and publicly reported at the contract level, rather than at the plan level. This is the case even where plans might serve significantly different populations, networks, and geographies. MedPAC therefore has recommended that at a minimum quality measures be reported at the local level, and we are supportive of this recommendation.44 While the entirety of the Medicare Advantage program would benefit from reporting at the local level, this is particularly important for plans targeted at people who are dually eligible for Medicare and Medicaid. For example, dual-eligible special needs plans (D-SNPs) are only made available to people who are dually eligible and are supposed to be tailored to meet their needs, yet a D-SNP can be embedded in an insurer’s broader Medicare Advantage contract that includes many general Medicare Advantage plans. This approach has several disadvantages. First and foremost, it can be misleading to people who are dually eligible when they go to sign up for coverage—the star ratings that they see for a D-SNP may reflect their performance for the general Medicare Advantage population, and not be specific to the dual-eligible population. Additionally, it hinders states’ ability to effectively contract with D-SNPs because they cannot evaluate plans’ performance for the dual-eligible population. Because of this, states either must require plans to submit additional documentation or decide about which plans to permit into their markets without this information, which is anecdotally what we hear happens most frequently.

Recommendation: We urge CMS to require all D-SNPs to operate on their own contract or on a contract with only other D-SNPs by state. We also urge CMS to consider requiring reporting at the plan benefit package level for all plans that serve a disproportionate share of people who are dually eligible.

Justification: Requiring each D-SNP to operate on their own contract by state would provide both people who are dually eligible and states with the information they need to understand plan quality and performance because the star ratings would be specific to the population and state. Furthermore, financial reporting, like medical loss ratio would also be available for D-SNPs, which states and researchers could then also use to better understand the financial performance of plans that are specifically targeted at the dual-eligible population. While our primary policy goal is to impact D-SNPs, CMS could require all plans that serve a specified number of people who are dual-eligible to also report under a separate contract by state (e.g., any plan that has more than 20% of their population that is dually eligible would be required to file under a separate contract). While states have no ability to influence these general Medicare Advantage contracts, this could benefit people who are dually eligible and comparing plans on Plan Finder, assuming this information was made publicly available.

Foster more transparency on state program design decisions for their dual-eligible population

Background: Every D-SNP must sign a contract with the state, often referred to as the State Medicaid Agency Contract (SMAC). In these contracts, ideally, states include requirements to ensure that people who are dually eligible’s D-SNP coverage works well with their Medicaid coverage (e.g., care coordination and reporting requirements), allowing these two programs to feel like one to the people who enroll in D-SNPs. However, these contracts are not publicly available today.

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Recommendation: We urge CMS to collect SMACs from the states or Medicare Advantage plans and post them publicly.

Justification: Making the SMACs publicly available not only fosters greater transparency but can support other states in managing their own programs. Anecdotally, states report struggling with how to best use these contracts to create alignment between their Medicaid programs and the Medicare program. If these contracts were made publicly available, states would be able to learn from their peers and borrow language from other states’ contracts. Furthermore, making these contracts publicly available represents an important program integrity activity. Advocates and researchers, for example, will be able to review the contracts, study the design of states’ programs or request improvements be made to the contracts.

Collect and report data specific to Employer Group Waiver Plans (EGWPs)

Background: Over five million Medicare beneficiaries receive Medicare coverage through Employer Group Waiver Plans (EGWPs), Medicare Advantage plans offered by employers and unions. The popularity of EGWPs among large employers has been increasing, yet there is substantially less information available about these plans relative to other Medicare Advantage plans. Because EGWPs are exempt from the bidding process, CMS does not collect information on benefits, cost-sharing, and anticipated gains/losses. As a result, MedPAC’s analysis of margins, which relies on data plans submit in their bids, cannot separately consider EGWPs and assess how their margins compare to other plan types. Due to the lack of data on EGWPs, there has been little research to-date assessing how these plans compare to other types of Medicare Advantage plans and evaluating EGWP payment policy. Because of the lack of data on EGWPs, policymakers do not have critical information on the extent to which these plans deliver value to beneficiaries and taxpayers. There are also concerns that EGWPs may enable employers to shift costs to the Medicare program although this issue is not well understood due to lack of data transparency.

Recommendation: CMS should publish the names of employers/unions participating in group plans, and the rebates and bonuses for each employer/union. This could be achieved by publishing the data elements related to employer group plan sponsors collected in the Part C and Part D Data Validation process. CMS should require EGWPs to submit data required of all other plans, including encounter data for Part A and B benefits and encounter data for supplemental benefits, and make reporting these data a condition for receiving bonus payments.

Justification: Improving data collection and reporting for EGWPs is necessary to better understand EGWP plan offerings including what supplemental benefits are offered and how benefit and cost sharing

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requirements vary across EGWPs. This information is also needed to enable comparisons between EGWPs and other Medicare Advantage plans.51

Conclusion

To ensure robust reporting and data accuracy, we encourage CMS to consider regularly auditing data submitted by Medicare Advantage plans. CMS should consider tying Medicare payment to compliance with data reporting requirements we recommend above. Both tactics – audits and connection to payment – have been identified anecdotally as best practices in states that collect ownership transparency data, for example, to improve the reported data’s accuracy and ensure true transparency is achieved.

We thank CMS for your efforts to improve data transparency in the Medicare Advantage program. We look forward to working with you on this important issue and would be pleased to provide further information on the above. Please contact Erica Socker at esocker@arnoldventures.org, Arielle Mir at amir@arnoldventures.org, and Mark Miller at mmiller@arnoldventures.org with any questions. Thank you again for the opportunity to respond to this Request for Information, and for your consideration of the above.

Sincerely,

Arielle Mir, MPA
Vice President of Health Care
Arnold Ventures

Erica Socker, Ph.D.
Vice President of Health Care
Arnold Ventures

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