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August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, D.C. 20201

Delivered Electronically

RE: Medicare Program; Request for Information on Medicare (CMS-4203-NC)

Dear Administrator Brooks-LaSure:

On behalf of agilon health, we appreciate the opportunity to respond to the Request for Information (RFI) on Medicare Advantage (MA). agilon health partners with primary care providers across the country to rapidly transition to full risk, accountable care models for their senior patients. Through our 20-year joint venture partnerships with primary care practices, we are fundamentally transforming the way care is delivered and paid for – resulting in a more sustainable future for primary care and better health outcomes for our communities.

agilon health believes that bolstering primary care is the key to fixing our fragmented health care delivery system. To strengthen primary care, there must be a new way of financing care that does not rely on reimbursement for each service provided, but instead encourages a holistic view of the patient's health care needs. With that in mind, agilon health built a new model that allows primary care physicians to practice the way they were trained, to spend more time with the most complex patients, and to coordinate care delivery across the care continuum. In our model, we enable primary care physicians to move from fragmented fee-for-service reimbursement to full risk capitation in just a year.

In full risk models, primary care physicians are responsible for care quality and the total cost of care for their patients. The agilon partnership in full risk models in traditional Medicare and in MA enables these physicians to access and deploy care managers, nurse practitioners, hospitalists, and other practitioners to provide and monitor care. We also provide the data that physicians need to identify high-risk patients and deploy resources accordingly, and we ensure that physicians have the information they need to leverage community partnerships to improve care.

The population health and data infrastructure that we build around our primary care physician partners restores the joy of practicing medicine, improves outcomes for patients, and creates a more sustainable future for payers. Our senior MA members have 45% fewer emergency room visits, 35% fewer hospital admissions, and 20% fewer hospital readmissions compared to fee-for-service Medicare benchmarks. We have also seen significant year-over-year improvement in quality scores and high patient and physician satisfaction with our model.

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Because MA plans are pre-paid and retain substantial flexibility in downstream contracting with providers and partners, we have been able to work with plans to ensure a workable payment model, consistency across quality metrics, and supplemental benefits and community resources that help address patients' total care needs. The full risk, capitated nature of these arrangements allows us to reinvest in primary care in our communities by drawing more primary care physicians into the model, increasing connectivity to local emergency rooms and hospitals, and enhancing care team resources so that primary care teams can spend more time with complex patients. Some specific examples of our successes include:

- Preventing avoidable hospitalizations with home care. Our partner practice provided a nurse practitioner to help manage pain medication and IV fluids for a patient in her home, preventing avoidable hospital admissions and allowing the patient to receive care in a more familiar and comfortable environment.
- Working with patients to accomplish their personal health goals. Through a complex care management program, our partner practice was able to assess the patient's mental and physical health and devise a care plan including daily goals of exercise, healthy eating, and greater responsibilities around the house. This plan provided the patient with a sense of purpose and manageable goals, enabling him to achieve greater quality of life over time while avoiding preventable trips to the hospital.
- Expanding access to care. Whether it is COVID-19 vaccines or primary care appointments, we work with our partners to ensure that patients have the health information and health care access that they need. Specifically, we prevent unnecessary trips to the emergency department by connecting seniors with primary care doctors early on.

As we consider the future of the MA program, we are pleased to share our feedback on the Administration's MA RFI. We support the Administration's exploration of ways to better align MA and the traditional Medicare advanced risk model portfolio. Our recommendations regarding the core principles that should drive this alignment and improvement follow.

Streamlining Model Design Elements

The MA program has been leading the adoption of risk-based and value based arrangements relative to other lines of business. According to the most recent Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) measurement report, approximately 58% of MA payments in 2020 were tied to alternative payment models, with nearly 30% representing two-sided risk arrangements.[1] agilon health and our partner practices participate in full risk models in both MA and traditional Medicare, including Comprehensive Primary Care Plus, the Medicare Shared Savings Program (MSSP), and the Global and Professional Direct Contracting (GPDC) model. We also plan to participate in the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model.

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[1] Health Care Payment Learning and Action Network: https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/.

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Our goal has been to align accountable care models, including full risk and robust quality measurement, across traditional Medicare models and MA for our physicians. We encourage the Administration to continue its work to ensure that advanced risk models in traditional Medicare are as strong as the MA program, with the two working in tandem to transform health care delivery. Simplicity and consistency between programs are key to achieving success in all approaches. We believe that streamlining requirements across programs and reducing differences in quality metrics, risk adjustment, and financial model details to the greatest extent possible will help the agency achieve its goal of having all beneficiaries an accountable care relationship by 2030. By streamlining model design elements and requirements, we can allow physicians to focus on patient care while successfully participating in value based care models for all of their senior patients.

Creating Stability and Predictability in Innovation Center Models

One of the key strengths of MA risk models has been the stability and predictability of revenue in advance and over the course of a given year. In MA, there is ample opportunity for participant feedback through annual processes, programmatic changes are communicated through broadly available memoranda, and mid-stream changes to payment methodologies are rare. This stability allows organizations transitioning to value based care to make longer-term investments in resources and programs that support better and more cost-effective patient care. In contrast, in many Innovation Center models, the financial models have been less stable and less predictable, including retrospective updates, changes to risk adjustment, and other modifications that can create significant and disruptive fluctuations. For example, Direct Contracting Entities (DCEs) are seeing extensive adjustments in their benchmarks throughout a performance year, in some cases by as much as 10%.

In the advanced risk environment, where performance is not clearly determined until three to six months after a performance year, DCEs and ACOs are often surprised at reconciliation to learn their performance is worse than expected due to retrospective or mid-year adjustments. These fluctuations make it more difficult to manage and report financial performance compared to the more stable MA contracts. The instability and unpredictability in traditional Medicare models may ultimately tip the balance in favor of MA as an accelerated driver of value based care. We believe that more can be done to replicate the success of MA in the traditional Medicare advanced risk model portfolio, specifically by making the financial methodologies in traditional Medicare models more transparent and predictable for participants.

Sharing More Information with Providers

Successful arrangements in MA arise from an environment where plans can provide comprehensive information to providers about patient backgrounds, health conditions, and treatments. Currently, most of the direct data exchange provisions are between the Centers for Medicare & Medicaid Services (CMS) and MA plans. We believe that greater CMS data sharing with providers, or requiring MA plans to share data with providers, would facilitate more care coordination and better care. Making the non-claim portion of the background more available would facilitate better quality care and result in better outcomes.

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Conclusion

We appreciate the opportunity to provide feedback on how the agency can improve the MA program and can better align MA and advanced risk models in traditional Medicare. We would be pleased to speak with you or your staff at any time about the future of the MA program and to discuss or comments and recommendations in further detail. Please do not hesitate to contact Claire Mulhearn, Chief Communications & Public Affairs Officer (claire.mulhearn@agilonhealth.com) or our team with additional questions.

Sincerely,

Steve Sell
Chief Executive Officer