Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

RE: CY2024 Physician Fee Schedule Proposed Rule

Dear Administrator Brooks LaSure:

Thank you for the opportunity to provide comments in response to the recently proposed changes to the 2024 physician fee schedule and several other policies impacting physicians under Medicare Part B. While we have concerns about the state of physician payment policy, we applaud the Center for Medicare and Medicaid Services for its forwarding thinking in other domains including the Medicare Shared Savings Program (MSSP).

About the agilon health Physician Network

agilon health, a publicly traded company, is the trusted partner empowering primary care physicians to transform health care through full-risk, value-based care. Today, groups within the agilon Network of physicians' care for senior Medicare patients within both rural and urban communities across 14 states. The agilon network of 2,700+ primary care physicians recognizes that our fee-for service (FFS) healthcare system is fractured, and that fixing it is a social and moral imperative to ensure physicians can continue to serve their communities and their senior patients can receive better health care.

The agilon health Physician Network provides Medicare Part B services to seniors across 32 communities and counting. Our network includes independent primary care physician practices, multi-specialty practices, practice associations, hospital physician groups, and hospital systems. We are united by our deep commitment to caring for seniors in our communities and our shared desire to provide accountable care that improves patient experience, health outcomes and physician satisfaction. In 2023 alone, the agilon Network of Physicians will reinvest more than $250 million of shared savings into local primary care within the communities we serve.

Together with agilon health, we have invested in a Total Care Model that puts our partnership at full risk for the total cost of care for our nearly 500,000 Medicare Advantage and ACO REACH patients. As part of ACO REACH, our Network includes 8 Accountable Care Organizations (ACOs) located across Hawaii, North Carolina, New York, Ohio, Pennsylvania, and Texas. These 8 ACOs are comprised of 12 independent physician groups, caring for a collective attributed population of about 90,000 Medicare FFS patients through ACO REACH.

Our Network physicians provide care to enrollees in traditional FFS Medicare as well.

Executive Summary

As you know, physician payment policies set forth in the yearly physician fee schedule have direct, immediate impact on FFS reimbursement and indirect, delayed impact on value-based care models under Medicare Advantage and CMMI test models such as ACO REACH. While we understand that cuts to the CY2024 conversion factor are largely a function of statutory requirements and the implementation of new codes, we are nevertheless concerned about the immediate and long-term impact of these cuts.

Coupled with the impact of inflation, which is not accounted for in the proposed payment rates, we join many others in the industry in our concern over the long-term sustainability of physician payment in Medicare.

Additionally, proposed changes to the Quality Payment Program (QPP) will put more financial pressure on our physicians and many others across the country at a time when health workforce shortages plague our system and trends toward consolidation are accelerating. Independent physician practices are especially vulnerable. As QPP performance penalties increase and barriers to entry and success in value-based care are raised higher, physicians will struggle to keep their practices running independently or perhaps at all.

While our detailed comments below include warnings about the impact of certain proposed policies, we also appreciate that CMS has put forth proposals we strongly support as well. We are pleased to see CMS' proposal to implement the G2211 complexity code. This code more appropriately compensates primary care physicians for the time and effort required to provide care for complex patients. Underinvestment in primary care has been persistent for decades, and implementation of this code is a step in the right direction. Additionally, we applaud CMS for considering opportunities to offer higher risk tracks within the MSSP. As a Network united in our commitment to full risk accountable care models, we are very pleased to offer our experience and lessons learned in support of a global risk track centered in primary care.

Comments and Recommendations

Payment Stability and Sustainability

Stable and sustainable payment rates provide financial predictability for physicians, and reliable reimbursement sources encourage both new entrants into the workforce and sustained practice over the long term. Moreover, fair and sustainable payment rates for primary care services are essential to making primary care an attractive option for the future work force, which is vital to ensuring access to health care services for Medicare beneficiaries.

A vibrant primary care workforce underpinned by a sustainable payment system promotes higher quality and improved patient outcomes. When patients have consistent access to a primary care provider (PCP), they can develop long-term relationships with their doctors who are then better positioned to understand their health history and provide personalized care. This continuity of care helps to prevent unnecessary utilization and hospitalizations, improve disease management, and enhance overall patient satisfaction. Moreover, a well-functioning primary care system plays a crucial role in reducing health disparities among different populations. Stable and adequate Medicare reimbursement for primary care services can help incentivize physicians to practice in underserved areas and care for patients with complex medical needs.

CMS' current proposal to cut the Medicare Conversion Factor (CF) by 3.3% does the opposite. **Across our network, the proposed cut, coupled with inflationary pressures, will result in an estimated 2-5% decline in overall traditional FFS Medicare reimbursement for each of our practices.** This decline will directly impact the overall financial health of our practices by placing undue financial pressure on the traditional FFS Medicare side of our businesses. What's worse, we know this trend of downward adjustments to the CF will continue, due in large part to the same statutory requirements and limitations causing the CY2024 cuts.

We are also concerned that this downward pressure over time will stall industry-wide investments in value-based care. The transition to value-based care often requires upfront and ongoing investments in practice change, care coordination, health IT infrastructure, and quality improvement initiatives (to name a few). Unstable and unsustainably low reimbursement rates for fee-for-service Medicare will limit the financial resources available to providers to make such deep investments and threaten the future viability of value-based care models.

We acknowledge that CMS' proposal to implement the G2211 complexity code will moderate the overall negative impact of declining payment rates for primary care providers under the proposed rule. **We support the finalization of this proposal.** However, we recognize the impact this will have on specialty care, as many of our Network's partners are multi-specialty practices. We share in industry-wide concern that the statutory schema underpinning the PFS creates conflict between medical specialties. While primary care is in desperate need of deeper investments such as the G2211 code, it should not be forced to come at the cost of other critically important specialty care. **CMS should explore all regulatory options to prevent important investments in primary care from competing with fair reimbursement for other specialties.**

Impact on Accountable Care Models

We strongly support CMS' goal of achieving a future Medicare system built on accountable care. Yet falling reimbursement rates in FFS will result in an untenable financial landscape for these very programs, threatening their viability. As rates established under the PFS decline to falsely low levels, the baseline costs for services provided to ACO-aligned beneficiaries may fall lower as well. As a result, future benchmarks may reflect this underinvestment and erode ACO's ability to achieve savings. Further, benchmark calculations typically include trend factors that adjust for projected growth in healthcare costs. If the PFS payment rates fail to keep up with actual cost trends, the benchmarks may not adequately reflect the current and future cost landscape.

In the Medicare Advantage program, benchmarks are also set using FFS beneficiary costs. As FFS costs fall, MA plans will find it more difficult to achieve savings and reconsider plan features such as benefit design, supplemental benefits, and beneficiary cost-sharing. These changes would directly impact patient access to care and erode providers' ability to achieve savings under sub-capitated arrangements for their MA population.

Overall, as success in accountable care models becomes increasingly challenging, there is less incentive to participate. **The current PFS methodology set by MACRA threatens our collective potential to reach CMS' goal of 100% of Medicare enrollees in an accountable care relationship.**

Changes to the QPP

Additionally, we have significant concerns over proposed policies that would modify the Quality Payment Program. First, we point out that while the QPP offers two tracks – the Merit-based Incentive Programs (MIPS) and the Advanced Alternative Payment Models (AAPMs) track – we are aware that it is CMS' goal to help providers transition into AAPMs. With this in mind, we strongly encourage CMS to reconsider proposals to increase MIPS bonus/penalty thresholds and shift AAPM bonus eligibility determinations from APM-level to provider-level.

CMS proposes to increase the MIPS performance threshold determining whether a provider is given a bonus or a penalty to 82 points (from 75) along with other proposed changes. As our health care system

continues its reemergence from the COVID-19 pandemic and providers are readjusting to MIPS, potentially without the prospect of hardship exemptions, we believe it is imprudent to raise the performance threshold. CMS' own estimates demonstrate this as 54% of clinicians are expected to be penalized under this new threshold. **We strongly recommend that CMS consider delaying implementation of the higher performance threshold.**

CMS also proposes to determine eligibility for qualifying APM participants (QPs) at the individual provider level rather than at the APM level, as is current policy. Total cost of care (TCOC) models like ours are reliant on the ability to incentivize integration between primary and specialty care and ensure that specialists provide high-value care to our attributed patients. However, many specialists care for a much smaller population of attributed patients than primary care physicians. We understand this can sometime disincentivize ACOs from including specialists. However, we believe that allowing specialists to qualify for AAPM bonuses as a function of their participation in an APM can also be an incentive for them to join. For multi-specialty groups like many of our partners, the prospect of primary and specialty care providers qualifying for AAPM bonuses is an incentive for the group to enter an AAPM as well. If CMS finalizes this proposal, we believe that fewer providers will qualify. **Instead, we strongly encourage CMS to consider performing these determinations at both the individual and entity level so that all participating providers who are eligible receive an incentive.**

Full-Risk in MSSP and Beyond

Though our physician network has largely focused on ACO REACH as an avenue to assume full-risk for the Medicare FFS population, we strongly support the development of a permanent global risk track within MSSP. Our deepest concern is a future state where our ACOs are disrupted or, worse, dissolved because there is no full-risk program available to transition into. Without an avenue to sustain our ACO models, opportunities to reinvest in and provide better care, improve our patients' experience, and ultimately achieve cost-savings for this population would be jeopardized.

As our Network contemplates the future of full-risk models, we encourage CMS and CMMI to consider a multi-faceted approach wherein ACOs may choose a permanent full-risk track within MSSP or elect to participate in a CMMI demonstration model such as ACO REACH or its successor. This multi-faceted approach would support CMS' 2030 goal of reaching 100% of Medicare enrollees in accountable care and encourage provider participation and continued innovation. To ensure a reasonably smooth transition for existing REACH ACOs, **we urge CMS to establish an MSSP full-risk track centered in primary care and simultaneously either extend the ACO REACH model by 1 year for existing participants or announce its successor by 2025.**

MSSP Full-Risk Track Design

A full-risk track in MSSP would support the continued proliferation and growth of total cost of care models which, in our experience, more successfully address cost, achieve better outcomes, and improve patient satisfaction within traditional Medicare. In designing a full-risk track in MSSP, CMS should build upon prior models and existing MSSP and ACO REACH successes. ACO REACH and prior test models have offered ACOs the ability to take on full financial risk with additional regulatory flexibility not currently available in MSSP. To this end, CMS should consider incorporating the following design principles in a full-risk track:

1. **Provide a full-risk option with no more than a 2% discount.** It is reasonable to expect CMS to extract savings from a full-risk track in MSSP, similar to existing discounts in ACO REACH. However, this must be weighed against incentives to attract participation. A reasonable and

sustainable discount rate of 2% strikes such a balance. Higher discounts challenge the actuarial soundness and incentive for ACOs to participate in a full-risk program.

2. **Design and implement fair and robust benchmarks that address the ratchet effect and reward and retain efficient providers.** To attract and retain existing, efficient ACOs CMMI should design benchmarks that do not inadvertently put historically efficient ACOs at a disadvantage. CMS' previously finalized and currently proposed policy changes to MSSP benchmarks are positive steps. A full-risk track should employ innovative benchmarking solutions, including setting ACO spending targets based entirely on that of ACOs' regions with no reliance on ACO participants' historic spending or need for a prior savings adjustment. This would provide a sustainable path to participation for ACOs whose spending is historically below that of its region.

3. **Leverage ACO REACH learnings on quality measurement to enhance MSSP's quality measurement approach**. In general, a simplified set of quality measures and reduced reporting burden will help attract ACO participation. The ACO REACH program implements a streamlined approach to quality measurement that moves away from exhaustive reporting and instead focuses on key claims-based measures that indicate performance against quality goals. Those measures include unplanned admissions, readmission, timely follow-up, and patient experience. This approach is not only preferrable, but also affords ACOs the time and resources to focus on other critical priorities such as health equity.

4. **Maintain flexibility for ACOs to select participating providers by allowing TIN/NPI ACO enrollment.** CMMI models have allowed ACOs to define participating providers using a combination of TIN and national provider identifier (NPI). By contrast, MSSP requires TIN-only provider selection, which limits ACOs to including all specialist providers within a TIN regardless of how well they align with the care delivery priorities of the ACO. With TIN-only provider selection, ACOs are more likely to exclude entire specialist provider groups, and even multi-specialty groups that include primary care providers, due to the potential impact of the specialists on their underlying model performance. This also creates an incentive for TIN-splitting, creating new separate TINs for primary care and specialists, which adds an unnecessary administrative burden for providers and CMS. The Pioneer and Next Generation ACO models allowed ACOs to use a TIN-NPI combination to identify providers which enabled them to create more focused high-performing provider networks.

5. **Provide financial flexibility for primary care ACO models to compensate providers.** In ACO REACH, every participating provider agrees to have FFS Medicare payments reduced by a set %, eventually reaching 100% population-based payments. To replace this lost revenue, the ACO enters into an agreement with its providers to reimburse them for services provided. Requiring population-based payments to participating providers, as in the REACH program, can be challenging because some primary care providers have more difficulty transitioning to this arrangement, particularly in a model where there is already accountability for the total cost of care. Such arrangements should be a voluntary option for ACOs and its participating providers, ensuring that population-based payments do not create disincentives for enhancing primary care, which would counter the shared goal between CMMI, CMS and ACOs to promote increased utilization of primary care.

CMS should expect highly confident and successful ACOs to join this new track. CMS's aim should not be to attract unsuccessful ACOs but to ensure it designs a model that will generate savings to Medicare

while providing ACOs with stable benchmarks and the flexibility to innovate and improve patient care. As an option, CMS could employ an early termination policy as was done in REACH to prevent ACOs from leaving the program before the end of their agreement period if the model became financially unfavorable for them.

Conclusion

Thank you for the opportunity to share our comments in response to the proposed 2024 physician fee schedule rule. The agilon health Physician Network stands ready as a resource to as you work to prepare final policies. If any questions arise, please do not hesitate contact Claire Mulhearn, Chief Communications &Public Affairs Officer, at Claire.Mulhearn@agilonhealth.com or Katie Boyer, Director of Policy & Government Affairs, at Katie.Boyer@agilonhealth.com.

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