May 29, 2024

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

RE: Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks La-Sure:

Thank you for the opportunity to provide comments in response to CMS' request for information (RFI) on Medicare Advantage (MA) data. We applaud CMS for its attention to this important topic, particularly the ways in which MA data supports and interacts with value-based care arrangements between providers and MA plans. As MA enrollment grows, there is significant opportunity to leverage the program toward CMS' accountable care goals by improving the context in which risk-bearing providers and MA plans work together.

About the agilon health Physician Network

The agilon health Physician Network is comprised of 2,400+ primary care physicians providing care for nearly 650,000 Medicare patients in 30+ rural and urban communities across 13 states. Our network includes independent primary care physician practices, multi-specialty practices, practice associations, hospital physician groups, and hospital systems.

We believe our nation's fee-for service (FFS) healthcare system is broken, and that fixing it is a social and moral imperative. Individually and as a Network, we are deeply committed to delivering patient-centered care resulting in better outcomes and a more satisfying experience for patients and providers. We believe that value-based care is the best path to achieving these goals. That's why, together with agilon health, we have invested in a Total Care Model that puts our partnership at 100% upside/downside risk (full-risk) for the total cost and quality of care for our entire Medicare population across Medicare Advantage (MA) and the ACO REACH Model. We also participate in the highest risk track of the Medicare Shared Savings Program (MSSP).

In 2022, our Network collectively achieved a 99.8% quality score and returned $24 million in savings to the Medicare Trust Fund through our participation in ACO REACH. In 2023, through our full-risk, shared savings agreements with Medicare Advantage plans and in combination with shared savings realized through REACH, our Network reinvested $200+ million into local primary care within the communities we serve. Since 2018, we've reinvested more than $550+ million in total. These figures collectively demonstrate our commitment to improving quality, bending the cost curve, and sustaining the primary care profession.

Background

Each of our Network partners, most of whom are independent primary care practices, have taken the leap into full-risk accountable care. As you know, accountable care is associated with lower costs to patients and the health care system as well as better coordinated, higher quality care. In accountable care relationships like ours, our most vulnerable patients are prioritized and closely managed by their doctor to ensure their health is protected. We provide them with wrap-around care which can include house calls, addressing social determinants of health (SDOH), and including family care givers in care plans. Moreover, we are enabled to coordinate the right care, at the right time, in the right setting, which protects our patients from unnecessary and expensive services that do not improve their health.

The agilon health Physician Network fully supports CMS' goal of ensuring that by 2030, 100% of Medicare enrollees have an accountable care relationship with a health care provider. As our health care system subsequently becomes more focused on person-centered, accountable care, the demand for and use of comprehensive patient data increases exponentially. Thanks to the many efforts at CMS and its sister agencies, providers have begun to leverage multiple data sources to build an ongoing, longitudinal understanding of their patients' health status, health care encounters and opportunities to improve outcomes and lower costs. These tools, coupled with the financial incentives inherent to value-based, accountable care arrangements empower providers to accept risk and reallocate resources to focus on individual patient needs. However, there are significant data gaps, particularly in MA, that should be addressed.

Executive Summary

Comprehensive, actionable data is crucial to success in value-based care arrangements, particularly those involving full-risk for the total cost and quality of care. Providers like those in the agilon health Physician Network taking sub-capitated risk from MA plans carry the same risk for their attributed patient population that the MA plans do. Yet, the granular data available to CMS and the plans is not shared with those risk-bearing providers, disrupting their ability to make real-time care decisions as well as accurately project current and future utilization and cost trends.

Recommendation: CMS should require MA plans to provide existing, complete data sets to downstream, risk-bearing providers for the patient population attributed to them.

- These files should not be altered or masked, only filtered to include information for attributed patients.
- They should not be delayed more than two weeks from the time the data is sent to or received from CMS.

Comments

The Medicare program holds great potential to achieve even greater quality, cost and outcomes improvement by equipping risk-bearing providers with more complete and timely data. The prospect of real-time or near-real-time data feeds to inform care decisions, clinical interventions and clinically appropriate diversion from high to low-cost settings is exciting. Some of this is possible through existing admission, discharge, transfer (ADT) feeds and health information

exchange (HIE) relationships, though neither hold comprehensive, ongoing data sets for patient encounters at all the various entry points in health care.

Data Access in MA VBC Arrangements

For providers like those in our Network who are committed to accountable care and have, as a demonstration of that commitment, taken full risk for Medicare Parts A & B from MA plans, the chief enabler for success is **predictability**. Through our partnership with agilon health, we can view a streamlined dashboard comprised of data from disparate sources to better understand who our most vulnerable patients are and when they are utilizing health care benefits through Medicare. To remain viable as a business model, we employ sophisticated forecasting techniques to help us predict utilization and cost trends to manage our financial risk for the total cost and quality of care for our attributed patients. Predictability allows us the confidence to remain engaged in total cost of care risk and make significant investments in practice transformation to better care for our patients.

However, such forecasting is predicated on comprehensive data access; claims, cost, coverage and risk data for each attributed patient becomes essential for VBC models like ours to thrive and self-sustain. This data is provided directly from CMS to risk-bearing providers in various Traditional Medicare ACO programs, and it works very well. Yet, in Medicare Advantage, MA plans offload financial risk to providers but are not required to – and therefore do not – share the comprehensive data necessary to manage that risk. Further, MA plans make independent decisions about their benefit structures, pricing/bids, utilization, cost-sharing, etc., which flow through to our costs as our attributed patients utilize their health benefits, but the specifics of those decisions are not visible in the data sets we receive from them.

By contrast, CMS and MA plans exchange very detailed, standardized data files outlining payment data, patient encounter data including detailed cost information (e.g., per-unit costs, cost-sharing, allowable amount, paid amount, etc.), and diagnosis codes related to risk adjustment. Rather than sharing these existing, standardized, comprehensive files with us, we instead receive significantly altered and often delayed, non-standard data files that vary in format and quality, with several fields masked, combined or otherwise distorted. These distortions, coupled with lags of up to three months, prevent us from understanding real-time developments and accurately forecasting future developments.

Without complete and timely data, risk-bearing providers are challenged to manage the same risk that the plans manage for the same set of attributed patients, impacting our ability to drive value in Medicare.

MA Data Files

The data files containing the information we need to appropriately manage the risk we carry for our attributed patients are comprised of the following file formats, which are exchanged between CMS and MA plans today. The data fields in these files are not masked or altered in any way, avoiding the challenges we currently have with distortions, and are presented in a standard format across all

payors. Moreover, they are exchanged at a regular, timely cadence, shortening the lag time between a patient encounter and data delivery.

1. Monthly Membership Report (MMR)
    - Purpose: Provides payment and enrollment data from CMS to MA plans for all members.
    - Use to risk-bearing providers: Ensures we know who the plan has attributed to us, which programs patients are associated with, and the current risk score of each attributed patient. This information is critical for sub-capitated models like ours.
2. Model Output Report (MOR)
    - Purpose: Reports condition codes (HCCs) included in a beneficiary's risk score.
    - Use to risk-bearing providers: Ensures conditions are correctly accounted for (including codes we have voided/deleted) and, if not, triggers an investigation of the data gap.
3. CMS Daily Transaction Reply Report (DTRR)
    - Purpose: Provides detailed information to help drive valuable clinical programs, such as hospice, kidney care, and important program dates.
4. Medicare Advantage Organization (MAO)-004
    - Purpose: Informs MA plans about the risk adjustment eligibility of diagnoses submitted on encounter data and chart review records.
    - Use to risk-bearing providers: Allows for a reconciliation of diagnosis codes evaluated by providers to what has been accepted by CMS for risk adjustment.
5. Prescription Drug Event (PDE)
    - Purpose: Reports standard fields summarizing prescription drug cost and payment data for Part D claims.
    - Use to risk-bearing providers: Helps us understand the cost of Part D drug benefits for MA contracts in which we take Part D risk.
    - Use to risk-bearing providers: Provides real-time information on our patients and the transactions initiated by the MA plan.
6. Encounter Data in 837 EDI Format
    - Purpose: Plans send claims encounters and chart review records (CRRs) to CMS in this format, as required.
    - Use to risk-bearing providers: This data, as sent to CMS, would provide us with a fuller picture and deeper understanding of utilization activity for our attributed patients. Access to the same file and format sent to CMS could replace the variety of files and formats we currently receive from MA plans.

Recommendation

The agilon health Physician Network recommends that CMS require MA plans to provide these complete data sets to downstream, risk-bearing providers for the patient population attributed to them.

- These files should not be altered or masked, only filtered to include information for attributed patients.

- They should not be delayed more than two weeks from the time the data is sent to or received from CMS.

We understand that MA plans may believe some of the data in these files is proprietary, and in the context of fee schedule contracting that may be sensible. However, when contracting to offload risk and share savings, downstream providers require this data to perform against the contract and ultimately drive value for each patient and the Medicare program.

Sub-capitated Arrangements with MA Plans

To better illuminate how these value-based arrangements with MA plans work, we include modified excerpts from agilon health's S-1 form filed with the Securities and Exchange Commission (SEC) in Addendum 1. We understand there is an interest among policymakers in the mechanics of sub-capitated agreements between providers and MA plan. We hope this information is useful.

Conclusion

The agilon health Physician Network remains steadfast in its commitment to driving value and improved outcomes through full-risk, accountable care across Medicare programs. We believe we are among the vanguard of providers advancing primary care-led accountable care models, in partnership with CMS and MA plans. We again urge CMS to consider ways in which it can leverage its authority to compel or require MA plans to provide comprehensive data necessary for VBC providers.

Thank you for your consideration. We stand ready as a resource, should any questions arise. Please do not hesitate to 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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Addendum 1

Sub-capitated Arrangements with MA Plans

agilon health (agilon) enters into contractual agreements with payors in each of its geographies, under which agilon is financially responsible for the agilon health Physician Network partners' provision of a defined spectrum of healthcare services to attributed patients, in exchange for a defined PMPM fee for each of our members (which is also referred to as "global capitation"). The healthcare services for which agilon and the Physician Network are responsible under such arrangements generally include all healthcare costs which CMS considers as Part A and B costs, including hospitalization and facility costs, primary and specialty care provider costs, and ancillary services cost. In certain payor arrangements, agilon is also financially responsible for Part D pharmaceutical costs for prescriptions rendered to our members.

The global capitation fees agilon is entitled to receive from payor contracts are typically based on a defined percentage of the corresponding monthly premium payments which the payor receives from CMS for members attributed to PCPs within the Physician Network and covered under such contracts. Certain contracts between agilon and payors incorporate provisions in which agilon and its Physician Network are eligible to earn quality bonus payments based upon the attainment of defined quality performance criteria correlated to applicable STAR ratings criteria.

agilon has developed local contracts across multiple payors, along with national form contracts with certain key payors. As of December 31, 2023, agilon has relationships with 26 payors, including large national health plans as well as smaller local and regional insurers. Patients are able to select the plan and benefit design that meets their individual needs while the agilon platform enables a seamless experience regardless of plan or product for all patients and Physician Network partners.

Payors retain responsibility for paying claims. Funding under the applicable agreement is utilized by the payor to pay such claims, and agilon receives surplus distributions on a monthly or quarterly basis. In these arrangements, the payor maintains the responsibility for entering into contractual agreements with network hospitals, network specialty physicians, and ancillary or other providers. The agreements with payors outline the range of healthcare services for which agilon is financially responsible and at risk, the services for which we are contracted to perform on the payor's behalf and the key financial terms.

The majority of agilon's contracts are for terms ranging from one to three years and contain automatic annual renewal provisions. When agilon enters into a new payor contract, there are typically requirements by the payor for agilon to contribute risk-bearing capital to the local operating subsidiary or risk-bearing entity (RBE). This typically takes the form of letters of credit or restricted deposits, or the payor may retain a percentage of the capitation payments due under the applicable contract. Risk-bearing capital required by payors varies by payor and geography, but typically averages between 1.5-2.0% of projected annual gross revenue attributable to the corresponding agreement.