Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

Request for Input (RFI) Responses

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could describe current perspectives on reducing barriers to participation in population-based total cost of care (PB-TCOC) models and supporting primary and specialty care transformation.

Prior to PTAC's March 3-4, 2025 public meeting on this topic, PTAC received two responses from the following stakeholders listed below:

1. American Association of Orthopaedic Surgeons (AAOS)
2. American Academy of Physical Medicine and Rehabilitation (AAPM&R)

Following PTAC's March 3-4, 2025 public meeting on this topic, PTAC has received three responses from the following stakeholders listed below:

3. Kitty Wright, LMSW
4. American Hospital Association (AHA)
5. The agilon health Physician Network

For additional information about PTAC's request, see PTAC's solicitation of public input.

AAOS
American Association of Orthopaedic Surgeons

February 7, 2025

Physician-Focused Payment Model Technical Advisory Committee
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Physician-Focused Payment Model Technical Advisory Committee (PTAC) Request for Input on Reducing Barriers to Participation in Population-Based Total Cost of Care Models and Supporting Primary and Specialty Care Transformation

Submitted via email to PTAC@HHS.gov.

To the Physician-Focused Payment Model Technical Advisory Committee:

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are pleased to share feedback on the Request for Input on Reducing Barriers to Participation in Population-Based Total Cost of Care Models and Supporting Primary and Specialty Care Transformation. AAOS is supportive of PTAC's initiatives to improve the quality of population-based total cost of care models (PB-TCOC) and ensure that orthopaedic surgeons are leading interdisciplinary, patient-centered musculoskeletal care teams in partnership with Accountable Care Organizations (ACOs).

What kinds of organizations (e.g., physician-led ACOs, hospital-led ACOs, integrated delivery systems, etc.) are likely to be able to provide the kind of multidisciplinary, team-based, person-centered that will be needed for effective PB-TCOC models?

Although ACOs have demonstrated much success in enhancing the quality of care, while sharing savings and lowering costs, considerable obstacles remain. In many health systems, the management of musculoskeletal conditions is primarily centered around non-operative care, often handled by primary care providers (PCP). Insufficient support systems and training in managing musculoskeletal conditions for PCPs can result in challenges such as unnecessary imaging studies, non-value-added interventions, and delays in providing appropriate care to patients. Until patients can access musculoskeletal experts to discuss available evidence-based treatments, they are unlikely to benefit from their potential benefits and improved health. **For this reason, AAOS is proposing a mechanism for interaction between primary care providers and musculoskeletal specialist teams.**

At the specialty level, procedure-based bundled episode payment models, such as those involving total joint replacement surgery for osteoarthritis (OA) of the hip or knee, have been met with limited

success. While procedure-based bundled episode payment models have shown some success in cost reduction, they have not consistently achieved substantial improvements in clinical outcomes or addressed the broader goals of providing timely, equitable, and comprehensive specialized care. Achieving true value in specialized care for conditions like OA requires a more comprehensive and patient-centered approach that encompasses procedural appropriateness, holistic care, and considerations for diverse populations.

AAOS has previously stated that ACOs have the option to sub-capitate or share risk downstream with specialty practitioners, aiming to align incentives and promote cost reduction, quality improvement, and patient-centered outcomes. If the ACO chooses to keep all the risk, then they will be referring out into the normal fee-for-service (FFS) market for musculoskeletal subspecialty care and will have to choose between rationing care for their patients or working with partners who are on a different incentive system, which will make it difficult to reduce costs. Since ACOs are being held accountable for musculoskeletal outcomes under condition-based payments, they will need to establish systems to effectively manage these conditions.

To effectively improve care transition management to support physicians that operate with ACOs and population based-payments models, AAOS encourages PCPs to partner with teams of specialty physicians who have expertise in musculoskeletal care, with the support of CMS, to overcome the limitations of minimal training and ensure that patients receive optimal care for their musculoskeletal conditions. This collaboration fosters incentive alignment, promotes knowledge exchange, and improves patient access and experience by considering the patient's condition, alongside their preferences, values, and needs (also characterized as “Comprehensive Condition-Based Care”). AAOS believes that a payment model that incentivizes high-value care is going to be more effective than forcing ACOs to try and identify who is already providing high-value care in their community. This payment model could be a subcapitation within a broader ACO, or it could be a single capitated payment outside an ACO.

Some institutions have already implemented this model. One such place is the Musculoskeletal Institute at Dell Medical School in Austin, Texas. They have assembled a team primarily focused on the treatment of different musculoskeletal conditions. The team varies according to the condition that they are treating. By way of example, the treatment for knee pain includes an orthopaedic surgeon, associate providers (Physician Assistant/Nurse Practitioner), physical therapist, dietitian, and the support of a social worker to help with socioeconomic issues and care coordination. This team has been functioning under a condition-based payment for Lower Extremity Pain with their county health system for the past 4 years and delivers the full spectrum of treatment options including education, weight loss, physical therapy, medications, injections, durable medical equipment (DME), and surgery. When patients do require surgery, they are being discharged faster than the national average,

going home with a self-care routine more frequently than the national average, and avoiding readmissions better than the national average.

By implementing this team-based model, the Musculoskeletal Institute at Dell Medical School exemplifies the potential benefits of interdisciplinary collaboration and condition-based payment systems in improving the quality, coordination, and outcomes of musculoskeletal care. Such models have the potential to enhance patient experiences, optimize resource utilization, and promote a patient-centered approach to musculoskeletal health.

What are some specific potential pathways toward maximizing participation of different kinds of organizations in PB-TCOC models?

AAOS recognizes that the future of healthcare is based on emphasizing the reorganization of expert teams and implementing the shift towards value-based care. This Comprehensive Condition-Based Care model aligns with the principles of improving outcomes, decreasing costs, and empowering patients and physicians to collaborate for better health. This model envisions a healthcare system that is proactive, patient-centered, and driven by collaboration and evidence-based practices. It emphasizes prevention, effective care through delivery of high-value services, and aligning incentives to optimize outcomes and control costs. By embracing this vision, healthcare organizations can transform healthcare delivery and improve the overall health and well-being of populations.

The crucial elements for success in delivering high-quality care across practice types is the ability to organize teams with aligned incentives, establish data infrastructure, and manage costs to achieve a patient-centered approach, improve care coordination, and enhance overall value. AAOS believes that implementing these elements requires collaboration and engagement from all stakeholders, including healthcare providers, administrators, payers, and patients.

We recommend that the model include incentives to support potential participants, particularly those in private practice, who are eager to participate yet lack the resources to build the infrastructure required to participate in this type of model. Currently, many musculoskeletal practices exist that could take on a condition-based payment structure with minimal investment and adjustment. Often created by the expansion of Orthopaedic surgery groups, there are many examples of teams that already include Rheumatology, Physical Medicine and Rehabilitation, Primary Care, Physical Therapy, Podiatry, and Prosthetics/Orthotics. Such groups will be poised to take on pilot programs and prove the concept in conjunction with CMS. While internal organization may be required for many, new capital investment and hiring could be minimized.

We also recommend that for all participants, new models should begin with no risk and allow progression to risk-bearing as experience is accumulated. Special emphasis must be given to rural

locales where large geographic areas must be covered to gain efficiency. This will require more effective use of telemedicine from physician-to-physician, and not just from physician to patient. Due to low patient volume, participants may see large swings in performance which make risk bearing difficult.

CMS should create upside incentives for interested participants that would reward innovation and high-value patient care. We believe the program should be voluntary on a nationwide basis for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, better coordinated, and lower cost care for musculoskeletal conditions and who have or are willing to build the infrastructure necessary to carry out an episode of care approach to payment and delivery. A key component of this is ensuring that any payment structure used is one that accounts for inflation and other changes that have a direct impact on the financial viability of physician practices. Physicians want to provide high-quality, lower-cost care to patients, but they must feel confident that the economics of the model will also allow their practice to succeed.

Thank you for your time and attention to the thoughts of the American Association of Orthopaedic Surgeons (AAOS). AAOS looks forward to working closely with the PTAC on further improving alternative payment models. Should you have questions on any of the above comments, please do not hesitate to contact Lori Shoaf, JD, MA, AAOS Office of Government Relations at shoaf@aaos.org.

Sincerely,

Paul Tornetta III, MD, PhD, FAAOS
AAOS President

cc: Annunziato Amendola, MD, FAAOS, First Vice-President, AAOS
Wilford K. Gibson, MD, FAAOS, Second Vice-President, AAOS
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS
Nathan Glusenkamp, Chief Quality and Registries Officer, AAOS

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February 11, 2025

Terry Mills, Jr., MD, MMM
Soujanya R. Pulluru, MD
Co-Chairs
Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistance Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation – Request for Input

Dear Co-Chairs Mills and Pulluru:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in response to the above-referenced Request for Input (RFI). AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

AAPM&R appreciates PTAC's ongoing emphasis on driving accountable care through population-based total cost of care (PB-TCOC) models, including its interest in increasing specialty engagement and supporting specialty care transformation. AAPM&R has long recognized the importance of value-based care and the significant role that PM&R physicians can play in improving cost and quality outcomes. To that end, AAPM&R developed the attached Principles for Alternative Payment Models (APMs), which outline key elements that we believe are necessary to ensure that APMs support outcomes of the highest priority to patients, families, and caregivers. ***We encourage PTAC to consider AAPM&R's principles when developing recommendations to expand the reach of PB-TCOC models, as well as to increase the engagement of specialists in contributing to their success.***

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PM&R physicians are especially positioned to support the goals of PB-TCOC models given their pivotal role in managing patients' post-acute care (PAC) needs, as well as across the care continuum. They are uniquely trained to help oversee a patient's care trajectory, navigate patients through their recovery, and help patients achieve independence as quickly as possible. Physiatrists not only identify the rehabilitation potential of a patient, but also ensure the patient is triaged to the most appropriate setting of care to receive the most medically appropriate level of service. Furthermore, research shows that early physiatry involvement can lead to numerous benefits, including shorter length of acute inpatient stays and better functional outcomes.[1,2] Prioritizing PM&R participation in PB-TCOC models can therefore support the models' cost and quality goals, and we address opportunities to do so in our comments below.

Financial Incentives to Support Specialty Engagement

AAPM&R believes that APMs must strive to deliver high-quality, high-value care. Importantly, accountability for quality of care must include patient-reported outcome measures that are focused on function and quality of life. When compared to traditional quality measures, these measures can be far more indicative of patients' wellbeing and future health and health care utilization, as well as more reflective of patients' needs and long-term goals. Tools such as the Patient-Reported Outcomes Measurement Information System (PROMIS) Global-10 Survey (PROMIS-10) – which is a well-validated tool for collecting patient-reported data that can be used across settings and conditions – are readily available to incorporate into models' quality accountability frameworks.

Furthermore, we believe that model participation should evaluate performance on patient-reported outcome measures over a sufficiently long follow-up period. Particularly for functional outcome measures, longitudinally tracking patients for at least three months to one year is necessary to determine whether patients' care results in long-lasting improvements in functional status.

Finally, we believe that models should hold participants accountable for furnishing high-quality care through payment incentives tied to such patient-reported

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[1] Wagner AK, Fabio T, Zafonte RD, Goldberg G, Marion DW, Peitzman AB. Physical medicine and rehabilitation consultation: relationships with acute functional outcome, length of stay, and discharge planning after traumatic brain injury. *Am J Phys Med Rehabil.* 2003;82(7):526-536.

[2] Needham DM, Korupolu R, Zanni JM, et al. Early physical medicine and rehabilitation for patients with acute respiratory failure: a quality improvement projected. *Arch Phys Med Rehabil.* 2010;91:536-542.

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outcome measures. Without financial responsibility for maximizing such outcomes, including related to function, the risk is too great that model participants will focus on cost savings at the risk of long-term patient well-being. We note that financial accountability for such measures will also help to drive participation of relevant specialists whose contributions support desired quality outcomes associated with such measures.

Facilitation of Data-Sharing Between Primary Care and Specialty Providers
As we note in AAPM&R's APM Principles, we believe APMs must be data driven, and that interoperability is necessary to ensure appropriate communication, relationships, and quality measurements of care through day-to-day operations and to support transitions of care. However, we highlight the challenges that providers working in PAC settings face, given relatively low levels of certified electronic health record (EHR) technology (CEHRT) adoption among PAC providers. This is largely due to the high costs associated with operationalizing CEHRT and the fact that PAC providers were not eligible for the billions of dollars in federal incentives offered under the EHR Incentive Programs for the adoption and use of CEHRT. As a result, EHR adoption in PAC settings is uneven, with providers using a variety of often inadequate and non-standardized systems, and often resorting to self-developed templates to make their EHRs more user-friendly. This disparity creates barriers to seamless sharing of data between primary care and specialty care providers, who often rely on the EHRs of the PAC facilities in which they furnish care. Federal investments similar to those offered under the EHR Incentive Programs are therefore needed to enable PAC providers to adopt CEHRT and allow for seamless exchange of data between providers across settings.

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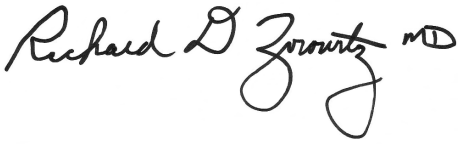
Thank you for your consideration of our comments. If you have any questions or would like more information, please contact Carolyn Millett at cmillet@aapmr.org or (847) 737-6024.

Sincerely,



Richard Zorowitz, MD, FAAPMR
Chair, AAPM&R Innovative Payment and Practice Models Committee

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Principles of Alternative Payment Models

Introduction

As healthcare continues its shift away from fee-for-service (FFS) reimbursement and towards alternative payment models (APMs) that focus on value-based care, there is an increasing need to ensure that models are designed to support outcomes of highest priority to patients, families, and caregivers. This document outlines key elements necessary to achieve such a goal. AAPM&R urges other stakeholders and policy makers to consider these principles when developing, recommending, implementing, and evaluating APMs.

A Physiatrist

A physiatrist is a licensed physician (M.D. or D.O.) who has completed a Physical Medicine & Rehabilitation (PM&R) residency accredited by the ACGME, the AOA, or the Royal College of Physicians and Surgeons of Canada and meets the training and experience requirements for examination by the American Board of PM&R or the American Osteopathic Board of PM&R. Physiatrists, also known as PM&R physicians, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

Principles of Alternative Payment Models

1. **Collaboration and Coordination** – An alternative payment model must prioritize and incentivize collaborative and coordinated care.
    a. Collaborative and coordinated care should include medical specialties, nursing, behavioral health, and allied health professionals as necessary across the care continuum, including inpatient and outpatient settings.
    b. Coordination of care must ensure continuity and attention as patients transition from one care setting to another or to the home.

2. **Patient-Centered Care** – An alternative payment model must emphasize patient-centered care and prioritize the needs of the patient to optimize health outcomes.
    a. To optimize health outcomes, care must be accessible and affordable for patients including those with chronic injury, illness, and activity limitations.
    b. Recognizing and accounting for social determinants of health must be a priority in all points of care.
    c. Improvement in patient function and quality of life must be the foundation for a successful model.
    d. Patient-centered care must take into account patient priorities, including circumstances related to availability of caregivers and other assistance.

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3. **High-Value Care** – An alternative payment model must prioritize the delivery of high-quality, high-value care.
    a. Physicians should coordinate care across the care continuum to best serve the patient.
    b. Care provided must be based on the best available evidence.
    c. Accountability for quality of care must include patient reported outcome measures focused on function and quality of life. Process and utilization metrics alone are not sufficient to assess patient outcomes.
    d. Models should reward high-quality care through payment incentives.
    e. Cost evaluation in models for demonstrating value must account for cost savings across the system, not just in certain silos of care.

4. **Accountability –** An alternative payment model must hold model participants accountable only for outcomes over which they have control.
    a. Quality and cost metrics used to determine performance must reflect the scope of services furnished by model participants.
    b. Alternative payment models must include accurate risk adjustment to ensure that model participants are not penalized for providing care to high-risk patients.

5. **Physician Engagement** – An alternative payment model must be driven through physician engagement.
    a. Alternative payment models should incorporate physicians in leadership structures to ensure that patient care needs are addressed adequately and to enable engagement from the provider community.
    b. Physician stakeholders and clinical champions must be given the opportunity to participate in development of alternative payment models.
    c. Alternative payment models must support physician autonomy in developing care plans and provide physicians flexibility to make independent clinical decisions.

6. **Incorporation of Physiatry** – An alternative payment model must consider the role of physiatrists when the model incorporates or benefits from rehabilitation care.
    a. Physiatrists must play a leading role in addressing function and optimizing quality of life, which are prime metrics in alternative payment models and patient-centered care.
    b. Physiatrists must be involved in model development to provide expertise and analysis that is unique to the PM&R specialty.

7. **Reasonable Risk** – Mandatory alternative payment models must allow for meaningful participation by providers with varying capacity to take on downside risk.
    a. To ensure flexibility, it must be recognized that some model participants may not have the population size to assume downside risk appropriately for the costs of care.
    b. Considerations must be made for model participants with a large proportion of high-risk patients that may not have the capacity to assume downside risk for the costs of care.

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8. **Availability of Resources** – An alternative payment model must ensure that participants are equipped with the resources they need to provide high-value care.
    a. Payment must be sufficient to ensure the delivery of high-quality, high-value care.
    b. Small practices must be supported to allow for model participation.
    c. Participants must be offered training and support in meeting the requirements of alternative payment models.
    d. Resources such as IT capability or provider network management should be made available to model participants as necessary.

9. **Data Driven** – An alternative payment model must be data driven.
    a. Data must be made available and accessible to all participants on a regular and timely basis.
    b. Data analysis and/or access to customized analytical assistance (e.g., clinical data registries) must be made available to model participants to support process improvement and optimization of care delivery.
    c. Alternative payment models must promote interoperability to ensure appropriate communication, relationships, and quality measurements of care through day-to-day operations and to support transitions of care.

10. **Flexibility and Efficiency** – An alternative payment model must eliminate barriers and improve efficiency to advance delivery of high-value care.
    a. Alternative payment models should encourage streamlined provider and care team communication and decision-making.
    b. Alternative payment models must support providers to optimize workflow and limit administrative burden, for example by eliminating prior authorization and unnecessary reporting requirements.
    c. Patient care must not be compromised when promoting efficiency.

Disclaimer
This AAPM&R Position Statement is intended to provide general information to physiatrists and is designed to complement advocacy efforts with payers and policymakers at the federal, state and regional levels. The statement should never be relied on as a substitute for proper assessment with respect to the specific circumstances of each case a physiatrist encounters and the needs of each patient. This AAPM&R statement has been prepared with regard to the information available at the time of its publication. Each physiatrist must have access to timely relevant information, research or other material which may have been published or become available subsequently.

BOG Approved 9/30/2022

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Physician-Focused Payment Model Technical Advisory Committee (PTAC)
U.S. Department of Health and Human Services
200 Independence Ave SW
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Subject: Public Comment on Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

Dear PTAC Members,

Thank you for the opportunity to provide input on the critical issue of reducing barriers to participation in PB-TCOC models and advancing primary and specialty care transformation. As a stakeholder invested in improving access to high-quality, value-based care, I appreciate the Committee's commitment to addressing the challenges and opportunities within these models.

I wish to highlight the following key areas that warrant attention:

Expanding Participation Among Underserved Populations

- Many underserved communities, particularly in rural and low-income urban areas, lack access to the necessary resources and infrastructure to participate in PB-TCOC models fully. Addressing social determinants of health (SDOH) through tailored incentives and targeted investment in community-based care networks can enhance engagement and improve health outcomes.
- Special consideration should be given to providers serving justice-involved individuals, whose care coordination often requires specialized approaches.

Addressing Organizational and Workforce Challenges

- Independent and small-group physician practices often face administrative burdens that deter participation. Streamlined reporting requirements, technical assistance, and financial support can facilitate their inclusion in value-based payment structures.
- Workforce shortages, particularly in primary care and behavioral health, remain a significant barrier to multidisciplinary, team-based care. Expanding loan forgiveness programs and increasing reimbursement for integrated behavioral health services within PB-TCOC models can support provider recruitment and retention.

Enhancing Data Sharing and Care Coordination

- Ensuring interoperability among electronic health records (EHRs) and incentivizing data-sharing agreements between hospitals, primary care providers, and specialty care providers can improve care continuity and reduce redundant services.
- Implementing standardized attribution methods that consider patient preferences and provider relationships can help ensure that accountability structures align with real-world care delivery.

Improving Payment Structures and Risk Adjustment

- Risk adjustment methodologies should be refined to adequately reflect the needs of patients with complex chronic conditions, social risk factors, and multi-morbidity, ensuring that providers are not unfairly penalized for serving high-risk populations.
- Consideration should be given to hybrid payment models that blend fee-for-service with prospective payments to support practices transitioning to PB-TCOC models while maintaining financial stability.

Strengthening Incentives for Specialty Care Integration

- Specialists play a crucial role in managing chronic diseases and reducing avoidable hospitalizations. Developing financial incentives that encourage specialists to actively collaborate with primary care providers through shared savings, bundled payments, or specialty-focused APMs can enhance clinical integration.
- Implementing policies that support virtual and community-based specialty consults for underserved areas can help close care gaps and promote equity.

I commend PTAC for its efforts to drive healthcare transformation and appreciate the opportunity to contribute to this discussion. I urge the Committee to consider these recommendations as they refine PB-TCOC models to ensure equitable access, provider sustainability, and improved patient outcomes.

Thank you for your time and dedication to this important work. I welcome the opportunity to further engage in discussions on these issues.

All my best,

Kitty Wright, LMSW
Master of Public Policy Candidate 2025
Andrew Young School of Policy Studies
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March 27, 2025

Terry Mills Jr., M.D., M.M.M, Co-chair
Soujanya Pulluru, M.D., Co-chair
ATTN: Physician-Focused Payment Model Technical Advisory Committee
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Request for Input Reducing Barriers to Participation in Population-Based Total Cost of Care Models and Supporting Primary and Specialty Care Transformation

Dear Co-chairs Mills and Pulluru,

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to share our comments regarding the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) request for input on barriers to transitioning to population-based total cost-of-care (PB-TCOC) and primary and specialty care models.

In particular, we urge the PTAC to:

- **Adopt common principles that will support the implementation of PB-TCOC, primary and specialty care models.**
- **Recommend removal of high/low revenue thresholds, which inappropriately prevent certain providers from entering primary and specialty care models.**
- **Recommend extension of the advanced alternative payment model (APM) incentive payments.**
- **Recommend more sustainable reimbursement to support the transition to value better.**

Our detailed comments on these issues follow.

COMMON PRINCIPLES FOR PB-TCOC, PRIMARY CARE AND SPECIALTY MODELS

Our members support the U.S. health care system moving toward the provision of more outcomes-based, coordinated care, and we continue to redesign delivery systems to increase value and better serve patients. Over the last 15 years, our hospital and health system members participated in a variety of APMs, including primary care and specialty care models as well as total cost-of-care models.

While the movement to value holds tremendous promise, the transition has been slower than anticipated and more needs to be done to drive long-term system transformation.

There are principles that we believe should guide the design of such APMs to make participation more attractive for potential participants, including hospitals, health systems and independent providers. These include:

- **Appropriate On-ramp and Glidepath to Risk.** Model participants should have an adequate on-ramp and glidepath to transition to risk. They must have adequate time to implement care delivery changes (e.g., integrating new staff, changing clinical workflows, implementing new analytics tools) and review data prior to initiating the program.
- **Adequate Risk Adjustment.** Models should include adequate risk adjustment methodologies to account for chronic risk factors and clinical complexity. This will ensure models do not inappropriately penalize participants for treating the sickest, most complicated and underserved patients.
- **Voluntary Participation and Flexible Design.** Model designs should be flexible, incorporating features such as voluntary participation and options for participants to leave models.
- **Balanced Risk Versus Reward.** Models should balance risk versus reward in a way that encourages providers to take on additional risk but does not penalize those who need additional time and experience before they are able to do so. A glidepath approach should be implemented, gradually migrating from upside-only to downside risk.
- **Guardrails to Ensure Hospitals Do Not Compete Against Their Own Best Performance.** Models should provide guardrails to ensure that participants are not penalized over time when they achieve optimal cost savings and outcomes performance. Participants must have incentives to remain in models for the long term.
- **Resources to Support Initial Investment.** Upfront investment incentives should be provided to support organizations in the transition to value-based payment. To be successful in such models, hospitals, health systems and provider groups must, for example, invest in additional staffing and infrastructure to support care delivery redesign and outcomes tracking.

- **Transparency.** Models' methodologies, data and design elements should be transparently shared with all potential participants. Proposed changes should be vetted with stakeholders.
- **Adequate Model Duration.** Models should be long enough in duration to truly support care delivery transformation and assess the impact on outcomes. Historically, models have been too short and/or have had multiple, significant design changes even within the designated duration, making it difficult for participants to self-evaluate and change course when necessary.
- **Timely Availability of Data.** Model participants should have readily available, timely access to data about their patient populations. Ideally, the Centers for Medicare & Medicaid Services (CMS) would dedicate staff and technology to helping provide program participants with more complete data as close to real-time as possible.
- **Waivers to Address Barriers to Clinical Integration and Care Coordination.** Models must include waivers to Medicare program regulations that inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.

We urge the PTAC to adopt these core principles for future APM model design.

REMOVING PROBLEMATIC LOW-REVENUE THRESHOLDS AS CRITERIA FOR APM PARTICIPATION AND INVESTMENT PAYMENTS

As mentioned above, hospitals and health systems are critical stakeholders in the journey to value. However, certain policies have hampered their ability to participate in certain models. For example, CMS has leveraged captured revenue to distinguish Accountable Care Organizations (ACOs) as "low-revenue" or "high-revenue," and by proxy, to identify ACOs as either physician-led (low-revenue) or hospital-led (high-revenue). The agency has then limited participation in certain APMs or qualification for advanced investment payments (AIPs) to only physician-led or low-revenue ACOs. It has based this policy on the faulty assumption that low-revenue ACOs perform better than high-revenue ACOs. **However, research shows there is no significant difference in performance between high- and low-revenue ACOs.**[1]

Furthermore, high-revenue ACOs often have more clinically complex, higher-cost patients attributed to their model. In addition, limiting eligibility for AIPs to only low-revenue ACOs inappropriately penalizes high-revenue ACOs, many of which are actually small organizations that critically need these resources for infrastructure investment to transition to APMs. For example, analysis suggests that critical access hospitals, federally qualified health centers and rural health centers are predominantly classified as high-revenue and therefore ineligible for AIPs. This partially explains the

[1] https://premierinc.com/newsroom/blog/pinc-ai-analysis-hospital-led-acos-perform-as-well-as-physician-led-models

disparity in APM adoption in rural and underserved areas, which the PTAC has previously highlighted. **We, therefore, urge PTAC to recommend the removal of these problematic high- and low-revenue thresholds that inappropriately preclude certain ACOs from obtaining necessary resources for infrastructure investment.**

EXTENSION OF ADVANCED APM INCENTIVE PAYMENTS

The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided incentive payments of 5% for providers participating in advanced APMs. These payments were designed to assist with the provision of non-fee-for-service programs like meal delivery programs, transportation services, digital tools and care coordinators that promote population health. However, MACRA statute only provided the advanced APM bonuses through the calendar year (CY) 2024 payment period. Congress has passed single-year extensions (although at lower rates) through the CY 2026 payment period. These incentive payments provide crucial resources for providers considering the transition to PB-TCOC, primary and specialty care APMs. **As such, we urge PTAC to work with CMS to urge Congress to extend these incentive payments, which will better support providers transitioning to primary, specialty and total cost of care models.**

PHYSICIAN ACQUISITION AND PB-TCOC, PRIMARY AND SPECIALTY CARE MODELS

Some presenters in the March PTAC meeting cited the acquisition of physician practices as a barrier to APM competitiveness. However, this discussion did not fully address the situation. Specifically, much like hospitals and health systems, physicians across the country face increased costs, inadequate reimbursements and administrative burdens from public and private insurer practices. These factors create major barriers to operating an independent practice. Furthermore, the transition to value-based programs often requires infrastructure investment for electronic health records, quality reporting, analytics and support staff, which many practices may not have the economies of scale to support. As a result, physicians are increasingly looking for alternative practice settings that will provide financial security so they can focus more on clinical care and less on managing their own practice. While a disproportionate amount of attention has been placed on hospitals' acquisition of physician practices, the reality is that large commercial insurers have collectively invested billions in physician practice acquisitions. Based on an AHA analysis of Levin Associates data, private equity, physician groups and health insurers have acquired the vast majority of physician practices during the last five years.[2] Comparatively, hospitals rank relatively low in the acquisition of physician practices. In fact, private equity-backed startups have acquired 65% of physician practices from 2019 to 2023, and insurers have acquired 14% of practices in

[2] https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf

that same timeframe. This is compared to hospitals and health systems that have only acquired 6% of physician practices.

Therefore, we urge PTAC to recommend policies, such as more sustainable reimbursement aligned with inflation. Doing so will better support all providers' abilities to transition to value-based care.

We thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Jennifer Holloman, AHA's senior associate director of payment policy, at jholloman@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

March 28, 2025

Terry Mills, Jr., MD, MMM Soujanya R. Pulluru, MD
Co-Chairs
Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistance Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW Washington, DC 20201

RE: Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation – Request for Input

Dear Co-Chairs Mills and Pulluru:

On behalf of the agilon health Physician network, we are pleased to respond to the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) request for information entitled, "Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation." We appreciate PTAC's recent examination of potential opportunities to develop and implement PB-TCOC models with accountability for quality and TCOC. Our experience in PB-TCOC models has largely been through accountable care organization (ACO) models, so we use the ACO terminology throughout our comments below.

About the agilon health Physician Network

The agilon health Physician Network is comprised of 2,700 primary care physicians providing care for more than 600,000 Medicare patients in 30 rural and urban communities across 12 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) health care 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 that reduces the chronic disease burden in our country, consistently delivers better health outcomes and provides a more satisfying experience for patients and clinicians. **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 allows us to assume financial risk for the total cost and quality of care for our entire Medicare population across Medicare Advantage (MA), the ACO REACH Model and the Medicare Shared Savings Program (MSSP).

In 2023, our Network's eight ACOs in the REACH model delivered high quality care to 90,000 Medicare patients and achieved significant cost savings. Collectively, our ACOs returned $37 million in savings to the Medicare Trust Fund while achieving an average quality score of 95%. Four of our eight ACOs were awarded a 100% quality score.

Since joining the model in 2021, our ACOs have delivered $71 million in Medicare savings to the Trust Fund, demonstrating the power and potential of value-based care models. In addition to our savings to Medicare, our model has allowed our Network to reinvest in 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.

Value-based Care is the Chassis for Payment Reform

Much progress has been made in the movement to value, and CMS' commitment to accountable care adoption through its 2030 goal is a critical driving force. Through value-based care programs, primary care practices can overcome barriers to entry with model features such as upfront investment funds, prospective payments, and fully aligned incentives that promote chronic disease management, care coordination, team-based care, and the infrastructure to segment patient panels, ensuring the right level of attention and resources are focused on each patient.

Additionally, our experience across multiple geographies, practice types and sizes, and patient mixes demonstrates not only better outcomes and lower cost[i, ii], but also the capacity for value-based care to help mitigate physician burnout. This is because value-based care models incentivize and enable PCPs to reorient workflows, spend more time with patients, and practice medicine the way they were trained to. As a result of our own transition to full-risk value-based care arrangements, **our independently owned physician practices are able to resist economic pressures to consolidate, sell, or close altogether, and many have expanded their practices.**

Despite the affirming evidence from value-based care models, more than half of primary care physicians still do not participate.[iii] There are numerous causes of this slower-than-anticipated uptake, not the least of which is long-term instability of our current payment system. Nevertheless, we are encouraged by the many (and growing) successes over the past decade. Congress and the Center for Medicare and Medicaid Innovation (CMMI) have each crafted essential programs in Medicare FFS that have sparked innovation in care delivery and payment**. We urge PTAC to promote model ideas that scale and build upon these successful programs to continue bolstering primary care and its move toward value.**

Select Responses to RFI Questions

1) What kinds of organizations (e.g., physician-led ACOs, hospital-led ACOs, integrated delivery systems, etc.) are likely to be able to provide the kind of multidisciplinary, team-based, person-centered care that will be needed for effective PB-TCOC models? a) What types of organizations would be best to serve urban communities, rural communities, or a mixture of communities?

Evidence indicates that physician-led ACOs outperform other models in delivering the types of care necessary to manage TCOC risk.[iv] Primary care practices such as ours are well positioned to participate in TCOC models, but only if they are well supported. Through our partnership with agilon health, our practices have already transitioned away from the Medicare FFS model in favor of full-risk (100% upside/downside) value-based care where payment is prospective, focused on high-value care, rewards quality, and promotes prevention, chronic disease management and care coordination.

These full-risk arrangements empower primary care providers to be at the center of their patient's longitudinal healthcare journey and shift the focus from volume of visits to optimizing patients' health and health care. Not only are our practices financially supported by this model, but our collective results demonstrate the power of physician led, full-risk value-based care.

Across our network, for the same or lower cost, we are providing better care and advancing shared goals. For example, in 2023:

- 75% of patients received their annual wellness visit;
- High-risk patients received 54% more touchpoints;
- ED visits and hospital readmissions were down 17% and 43%, respectively;
- Our network had a physician retention rate of 91%; and
- 90% of partner locations were accepting new patients vs. the national average of 70%.

Our model works across our varied geographies, including in rural, urban and mixed communities, because of the upfront investments and ongoing shared savings opportunities that are key features of our full-risk model. We believe deeply that continued investment in value-based care is how primary care will be sustained in the long-term.

2) What are some specific potential pathways toward maximizing participation of different kinds of organizations in PB-TCOC models?

a) What kinds of organizational characteristics are most important for determining potential pathways toward maximizing their participation in PB-TCOC models?

We strongly recommend that there be a pathway for full-risk models within the Medicare FFS program. Despite our commitment and significant investments, the only available full-risk program in Traditional Medicare – the Accountable Care Organization (ACO) REACH – is scheduled to sunset at the end of 2026. As of today, we have no future option or glidepath to continue our full-risk ACO model. A lapse in a full-risk option could be disruptive to the relationships our physicians have built with patients, and risks losing important momentum in moving primary care physicians to value-based care.

With respect to organizational characteristics, ACOs with experience in ACO REACH, including standard and high needs ACOs, are well-prepared to participate in PB-TCOC models. Other industry partners that assist provider groups in forming an ACO and entering risk arrangement are also likely interested parties. We are also aware of specialty groups that have formed a full-risk business portfolio with the desire to partner with ACOs and risk-bearing entities to share risk for certain patients, conditions and/or episodes of care. Other such organizations with the capacity and resources to manage significant downside risk would also likely be interested.

4) What is the anticipated distribution of types of organizations that are likely to be providing accountable care to Medicare beneficiaries in the future (physician-led ACOs vs. hospital-led ACOs vs. integrated delivery systems, etc.)?

a) What kinds of payment structures, risk structures and performance measures are needed in order to incentivize each of these different kinds of organizations to participate in PB-TCOC models?

b) What kinds of payment structures, risk structures and performance measures are needed in order to make it possible for each of these different kinds of organizations to be successful in participating in PB-TCOC models?

In terms of the best payment and risk structures within PB-TCOC models, we believe that full-risk models provide the best set of aligned incentives for primary care providers to invest in long-term practice transformation, employ population health strategies to keep their patient panels and communities healthy, allocate resources efficiently by targeting at-risk patients with more touchpoints, provide services that are not directly reimbursed or are under-reimbursed by Medicare, and ultimately sustain independent primary care practices through upside economics.

In our experience, the virtuous cycle in full-risk models leads to better quality of care, better outcomes, lower cost to patients, higher savings to benchmark and therefore the ability to invest in infrastructure and patient care that helps avoid and reduce adverse events such as expensive hospital admissions. In full-risk, these significant investments to support better cost, lower care and improved patient and provider experience make financial sense because of the level of accountability inherent in the model. This is not typically the case in lower-risk arrangements. The reinvestment of shared savings available in full-risk models also supports sustainable job creation as primary care providers surround themselves with a multidisciplinary team to support whole-person care.

Through full-risk arrangements, we have been able to make tangible practice changes such as:

- Extended office hours to increase access to care.
- Regular, proactive review of patient panels to identify care gaps and other opportunities to improve care.
- Hiring nurse managers, social workers and others to provide wrap-around patient care
- Placing nurses in local emergency departments to ensure our patients get the appropriate level of care.
- Specialized clinics focused on high-risk patient care.
- Establishing numerous, targeted and intensive clinical programs for patients with chronic illnesses, patients who are transitioning out of the hospital, and those who are nearing end of life.
- Partnering with specialty providers to support in-home care for our sickest patients.

Our ideal set of model parameters to promote PB-TCOC participation and program sustainability include:

- A 100% savings/loss rate with a reasonably low benchmark discount that progressively increases to a maximum of 3.5% over the duration of the contract period.
- A stable and consistent risk adjustment model.
- Tighter risk corridors to ensure shared savings to ACOs remain reasonable and support CMS' savings goals. We are supportive of tapered risk corridors, in which savings/loss rates decline progressively as gross savings percentage increases.
- Prior savings adjustments and removal of regional adjustment caps to address benchmark ratchet.

Additionally, advanced payment and prospective payment *options* are important flexibilities that ACOs have supported. These types of payment options ensure ACOs have timely access to the funds necessary to carry out population health and whole person care strategies. To be successful

in value-based care, especially in full-risk, you must invest in patient care that promotes wellness rather than waiting until a patient's health declines or they experience a health emergency. This is the way medicine should be practiced, and supporting this ideal state through timely payments is essential.

The way the REACH model offers prospective payments, for example, is to allow up to a percentage of benchmark to be paid prospectively. This ensures practices have the necessary cash flow (compared to FFS payments, which lag significantly) to engage in all the activities outlined previously in this letter. We enthusiastically support this option and recommend its inclusion in future models.

Capitation payments are also popular among some ACOs, but we do not view this as a necessary feature. We support optional capitation but believe strongly that ACOs should have flexibility to determine how they compensate their participating providers. This flexibility helps ACOs recruit new providers and practices, some of whom are not familiar or comfortable with capitation. Mandatory capitation would likely be a disincentive for many to participate.

5) What are the implications for the design of future population-based models?

a) If the goal is to streamline and simplify the number of models that are available, what should a more concise portfolio of models look like? How should a more concise portfolio of models vary for different kinds of organizations that are likely to be participating in population-based models?

b) What kinds of additional models could be designed to work with a more streamlined set of population-based models in order to test innovations in care delivery and payment methodology?

Our Network is among the vanguard set of primary care providers who have invested in CMS' vision to achieve 100% of Medicare beneficiaries in an accountable care relationship, and we believe full-risk arrangements optimize value-based care incentives to achieve the quadruple aim. As of today, there is no future option or glidepath to continue our full-risk ACO model if ACO REACH is not extended, expanded to MSSP or followed by a successor advanced risk ACO model.

If the goal is streamlining payment models, then we strongly support a continued focus on advanced risk ACO models that leverage the power of primary care to improve health outcomes and address cost. We support multiple pathways of achieving this goal, including further CMMI model tests to continue refining and expanding ACOs, as well as the establishment of a permanent full-risk option in the Medicare Shared Savings Program.

6) What are the best approaches for improving the predictability of ACO benchmarks and to effectively address the ratcheting effect?

a) How can current approaches be modified to more effectively address the ratcheting effect?

The current benchmark methodologies in existing ACO models create a downward ratchet effect each time an ACO's benchmark is rebased. This occurs across models in a variety of contract frequencies, but the effect is the same. This reality is untenable in the long term and

results in participating practices exiting the program, particularly if their ACO has a long history of participation in value-based care initiatives.

To address these challenges, we support including prior savings adjustments to benchmark calculations for ACOs that have previously participated in either MSSP or a CMMI ACO model (e.g., ACO REACH). We also support lifting caps on regional adjustments for all ACOs and providing ACOs with the larger of the two adjustments. We have come to favor these approaches over the use of an Administrative Benchmark, given the unintended consequences associated with reliance on prospective trends and model elements created to adjust benchmarks mid-year to correct trend misses (e.g. retrospective trend adjustments).

It is essential that new model proposals seek extensive stakeholder feedback and, in the case of a model test, be responsive to stakeholder feedback in an ongoing fashion. Further, broader discussions about transparency in how trends are calculated and adjusted in real-time are necessary for the continued development of and participation in PB-TCOC models.

7) What specific role may conveners/enablers play in increasing participation of certain kinds of providers in PB-TCOC models?

a) How can value-based care organizations better utilize conveners/enablers to increase participation?

b) How should payments to conveners/enablers be made? To what extent should conveners/enablers receive shared savings? How should these payments to conveners/enablers be distributed within the full risk payments of PB-TCOC?

Through our partnership with agilon health, we have demonstrated that value-based care enablers can significantly boost participation of independent physicians in PB-TCOC models in both Medicare Advantage and Traditional Medicare. By collaborating with independent primary and specialty care practices, agilon health provides essential resources, expertise, and infrastructure. This support helps physicians maintain their independence while transitioning from fee-for-service to value-based care and includes capitated payment models that offer stable and predictable financing, which is crucial for making the initial investments needed by independent practices, especially those new to value-based care.

Our financial model is structured so that shared savings is split between agilon and our practices at the ACO or risk-bearing entity (RBE) level (for MA contracts). Payments are delivered to the ACO or the RBE, as appropriate, and divided according to contract terms. Numerous other approaches exist and are implemented at other organizations, and we do not believe PTAC or CMS should prescribe how those arrangements are made.

9) What are best practices for improving attribution in PB-TCOC models?

a) In what ways might the best approaches for improving attribution vary for different kinds of organizations participating in population-based models?

b) What are the advantages and disadvantages of attributing the primary care provider to the patient versus using team-based attribution methods?

c) How do organizations effectively apply team-based attribution methods? How is accountability achieved?

It is our view that the attribution methodology established in and tested by the ACO REACH model sets a strong foundation for future models. We have found that, in the vast majority of cases, the methodology consistently and accurately attributes patients to our ACO through a variety of primary care provider types and filters out patients who seek only specialty care from our practices. In this model, non-physician primary care providers can drive attribution as long as they bill individually, promoting team-based care models and supporting increased access to primary care.

11) How should financial incentives be incorporated to encourage accountability for specialists that are not in integrated systems to coordinate with primary care providers?

a) To what extent might the appropriate financial incentives vary based on the type of organization that is participating in population-based models?

b) What are some effective approaches for ensuring that incentives are provided and shared with all team members?

We believe there first needs to be incentive, capacity and ability for primary care providers to routinely evaluate and pursue high-value specialty care. Higher levels of risk provide significantly more incentive to invest in sophisticated methods to identify high- and low-value services and subsequently refer to high-value providers. In our experience, full downside risk deeply influences the way a practice approaches provider arrangements and referral patterns because the ACO is accountable for the medical expense accrued by those providers.

Across our Network – which encompasses large metro areas, rural communities, and suburban communities, all with unique health care market concentrations – we are beginning to see bright spots where physician practices have been able to identify and approach specialists with clear data about their outcomes, cost and overall value. That data is extremely compelling as we select high-value partners for referrals and help providers change their lower-value clinical behaviors. In markets where referral networks are less concentrated, we have seen success in directing higher value, lower cost care. This data capability, however, is an example of the important but costly investments our Network, through our partnership with agilon health, has made as a direct result of full-risk economics.

More broadly, we acknowledge that specialty integration within PB-TCOC or ACO models is challenging, but we believe there is opportunity for future models to test new approaches. Such approaches could leverage quality measures specifically crafted for to specialty care coordination, and/or attach a bonus or incentive to certain high-value activities. Examples include existing outcomes measures that inherently reflect ACOs ability to coordinate with specialty care, measures that account for certain high-value activities (e.g. closing referral loops), and/or add-on codes/payments that target activities driving better specialty coordination.

16) What are factors that may influence the effectiveness of and use of current waivers in PB-TCOC models?

a) Are there other opportunities for enhancing the competitiveness of services and financial incentives in PB-TCOC models (including additional waivers)?

Flexibility and benefit enhancements/waivers have been a very popular feature of current and past test models and provide further incentives for organizations to participate. Moreover, beneficiaries with chronic care management needs are best cared for in a model with strong incentives to keep them healthy, out of the hospital and in regular contact with their primary care provider.

However, patients often don't understand that they are part of an ACO and therefore are unaware of the benefit of obtaining their care through ACO participating providers. By remaining within the ACO they are attributed to and ensuring any necessary specialty care is being coordinated through their ACO primary care provider, overall cost and patient out-of-pocket expenses can be reduced.

- To incentivize this ideal ecosystem, we have found that existing Part B cost-sharing waivers available in some ACO models have helped patients reduce their financial burden directly and indirectly by directing their care to the ACO network.
- Another existing waiver in ACO models in the skilled nursing facility (SNF) 3-day waiver, which waives the requirement for a 3-day inpatient hospital stay prior to discharge to a Medicare-covered SNF. This waiver helps reduce overall costs, including patient out-of-pocket costs, and improve patient experience, as unnecessary hospital days do not align with ACO or patient goals.

We recommend scaling these waivers more broadly to all PB-TCOC and ACO models, and providing more flexibility to enable and encourage uptake.

Finally, we recommend a new benefit enhancement that would waive the statutory restriction on Annual Wellness Visit scheduling, explicitly allowing AWVs to be scheduled and provided once a year at any time during that calendar year. Many MACs implement a requirement to elapse a full 12 months between AWVs, resulting in arbitrary barriers to care, administrative confusion, scheduling challenges and uncompensated care.

Conclusion

Thank you for the opportunity to share our comments in response to this RFI. If any questions arise, please do not hesitate to contact Katie Boyer, agilon health Senior Director of Policy & Government Affairs, at Katie.Boyer@agilonhealth.com.

Sincerely,

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[iv] *See* https://avalere.com/press-releases/physician-led-accountable-care-organizations-outperform-hospital-led-counterparts