AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

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September 9, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-P): Request for Information: Advanced Primary Care Hybrid Payment

Dear Administrator Brooks-LaSure:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments on the request for information (RFI) regarding Advanced Primary Care Hybrid Payments included in the calendar year (CY) 2025 Medicare Physician Fee Schedule (PFS) proposed rule.[1] The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence and quality of life of all older adults. Our 6,000+ members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician associates, pharmacists, and internists who are pioneers in serious illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. AGS believes in a just society, one where we all are supported by and able to contribute to communities where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the PFS.

We greatly appreciate that the Centers for Medicare & Medicaid Services (CMS) is seeking feedback on additional ways to reduce the strain on primary care practices. The AGS believes that a high-quality, cost-effective healthcare system results from care that is person-centered, team-based

[1] 89 Fed. Reg. 61724 (July 31, 2024)

and grounded in strong primary care. From our perspective, as called for in the National Academies of Science, Engineering and Medicine (NASEM) report, "Implementing High Quality Primary Care"[2], the payment system must value primary care and be focused on the health and well-being of the whole person across settings of care.

Primary care is not furnished by individual practitioners but by multi-professional teams that can respond appropriately and efficiently to patient needs. The current disparity in earnings between primary care and specialists is a major contributor to the workforce shortages of primary care practitioners (PCPs) and has created a crisis situation for primary care practices. The AGS applauds the proposal by CMS to provide payment for advanced primary care management (APCM) services that was included in the 2025 PFS proposed rule. The APCM proposal is an important step to better recognizing and supporting the capabilities that are essential to value-based primary care. We believe that CMS has effectively and thoughtfully addressed some of the RFI questions in the proposal. We have provided comments on that proposal and other provisions of the proposed rule in a separate letter. This letter focuses solely on the AGS' response to the topics in the RFI.

As part of the RFI, CMS identifies five components the agency considers foundational to value-based care:

- Streamlined Value-Based Care Opportunities
- Billing Requirements
- Person-Centered Care
- Health Equity, Clinical, and Social Risk
- Quality Improvement and Accountability

CMS asks almost 50 specific questions about issues within those components. Below we provide our perspective on what constitutes value-based care and generally discuss issues related to each component. We do not answer each question individually in this letter but will continue to carefully consider the questions and expect to provide CMS with additional feedback in the future.

Overview

The AGS believes that for care to be *truly* value-based it must include the following elements:

- A whole-person orientation to quality measurement that is centered around person-oriented outcomes that reflect the care goals of older adults as the threshold for higher reimbursement rather than basing higher reimbursement on condition- or specialty-specific outcomes.
- A multi-professional team of practitioners with the primary care practitioner central to facilitating care coordination.
- Strong primary care, as envisioned in the NASEM report with meaningful education for beneficiaries on the importance of every person having an established source of primary care.
- Processes that facilitate relationships between clinical teams and the patient/family/care partner so that what matters most to the patient is always at the forefront of the care plan.

[2] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. doi: 10.17226/25983 (National Academies Report).

- An intentional commitment to equitable care and reducing disparities by, among other strategies, financially supporting organizations that are embedded in underserved communities.

We urge CMS to take steps to improve beneficiary access to truly value-based care. Investments in value-based care transformation must be ongoing and stable with enough flexibility to correct the inevitable miscalculations and missteps inherent in any large-scale change. We agree that time-limited demonstrations may not create permanent transformation, even if available to all primary care practices nationally. Accountable Care Organizations (ACO) programs typically recognize quality and cost efficiencies by sharing the fruit of successful efforts, but they cannot be the primary source of funding for primary care transformation nor be relied upon to sustain a stable primary care delivery system. AGS believes that the proposed APCM payments support a strong primary care structure that is essential for other ACO participants to engage in value-based programs. The APCM payments will create a strong incentive and financial possibility for practices not already meeting the requirements of advanced primary care to rise to this level.

Quality measurement requires significant administrative resources and should be undertaken only for measures proven to impact patient care and outcomes. Quality measurement must be carefully considered and should focus on patient goals and experiences and person-oriented outcomes rather than on condition-or specialty-specific outcomes. Truly value-based care will require permanent access to telehealth services, which has become an essential means of delivering care, and improved Electronic Medical Records (EMRs) that easily permit patient information to be shared across different entities. If CMS does not have the authority to fund these elements, CMS should work with Congress and other stakeholders to ensure that they are secured or developed.

A. Streamlined Value-Based Care Opportunities

Component Summary: CMS describes this component as a steppingstone for primary care clinicians to move away from encounter-based payment and toward payments in larger units that are better tied to the relative resource costs involved in population-based, longitudinal care. CMS indicates it is "focused on creating multiple pathways to recognize delivery of integrated care across settings, and engagement in comprehensive, team-based, longitudinal care" and asks questions about maintaining existing effective accountable care relationships and networks and what services should be incorporated into future advanced primary care payment. Specifically, CMS asks about including evaluation and management (E/M) visits and other services such as care management and communication and technology-based services (CTBS) into advanced primary care payments. CMS inquiries about the roles other payers may play in care transformation and how to best support primary care clinicians that may be new to population-based and longitudinal management. CMS also asks whether there are other sources of data on the relative value of primary care services that CMS should consider when setting hybrid payment rates, beyond input provided by the American Medical Association's (AMA) Relative Value Updated Committee (RUC).

AGS Response: The AGS believes the most effective way to improve primary care is to appropriately pay for clinicians and practices to see beneficiaries. Primary care has costs associated with it that currently are not adequately compensated. AGS has been an active participant in the CPT

and RUC processes to develop and value care management codes. We favor the innovative payment of the proposed APCM codes but we also believe that value of the individual services packaged into a bundled code should be the basis of the valuation of the bundled code. Any capitated or hybrid payment should support elements of primary care that are poorly recognized under the fee-for-service payment system or administratively burdensome to report. It should also recognize care that is furnished by teams, rather than individual practitioners. The proposed APCM codes are an important first step to reducing the administrative burden associated with current coding and billing for clinicians who participate in advanced primary care models.

We believe all true primary care practitioners practice longitudinal care despite constrained resources. We agree that not enough primary care is currently team-based and interprofessional. All workforce projections make it clear that there will not be enough primary care clinicians to care for the population. Inclusion of NPPs into the calculus reduces but does not eliminate the shortage. Unless we use every qualified team member from nurse care manager or pharmacist to integrated behavioral health clinician to medical assistant and health coach or community health worker, our primary care delivery system will fail to meet the needs of our population. We also acknowledge that skills in population management team-based care are still developing, and the level of competence and capacity is variable. We believe that ACO organizational capacity and the growing tendency for new clinicians to join organizations helps to develop knowledge and skills. CMS can help accelerate this development by creating educational and support networks as is done in CMMI primary care demonstrations. To create a workforce more prepared for population-based and value-based care CMS should use levers in and beyond the Medicare physician fee schedule including promoting professional education to provide training in team-based population-based primary care. CMS should work with the Health Resources and Services Administration (HRSA) and Congress to ensure that programs such as the Geriatrics Workforce Enhancement (GWEP) and the Geriatrics Academic Career Awards (GACA) Programs have sufficient funding to meet the nationwide need for practitioners who are well-versed in care of older adults. The proposed APCMs will improve the viability and availability of practice sites that can take on the crucial role of training the next generation of clinicians. CMS could also consider a fee schedule enhancement for such training sites or prioritizing interprofessional team-based care for graduate medical education funding.

The AGS does not believe that the proposed or future APCM type payments are likely to erode participation in accountable care relationships. On the contrary, the payments will stimulate these relationships. A strong primary care system is a crucial building block to successful accountable care. CMS has proposed that clinicians participating in programs such as the Medicare Shared Savings Program meet the requirements to receive APCMs. This approach is both administratively simple and will help support and sustain existing ACOs. These programs have the best potential to build networks that are accountable for the total cost of care and to meet the extreme challenge of achieving engagement of non-primary care specialties. ACOs must currently dedicate their savings to support essential investments in primary care. If CMS has already supported that investment through consistent prospective payments, there will be greater opportunity to creatively use savings to promote better specialist participation.

We note that the APCM proposal pays separately for related E/M services, including an initiating visit. We support this approach. The AGS believes that including E/M visits in the advanced primary care capitation will create disincentives to furnish needed care. Bundling payment for E/M visits into the payment for related services creates a financial incentive to minimize the number of E/M services furnished. CMS has seen the effect of this incentive in its experience with global surgical periods and the limited number of follow-up visits furnished by the practitioner performing the original service. Those skewed incentives should not be incorporated into primary care. Care furnished should be driven by the patient's needs and care preferences and the payment model should not create incentives to see or not see the patient.

We believe that packaging payment for E/M visits into a capitation payment would put more rather than less strain on primary care practices. For many PCPs, including many geriatrics professionals, the vast majority of the services they furnish are E/M visits. Any error in the calculation of capitation of office visit services can be very destructive to primary care practices. If a portion of expected office visit expenditures is capitated to promote alternate visit types, there must still be an office visit fee that fully covers the practice expenses of individual patient visits in order to make the decision to see the patient or not see the patient a cost-neutral clinical and not an economic choice. Maintaining separate payment for E/M visits also allows an E/M or preventive medicine service to be an initiating visit for an APCM.

CMS asks about including certain other services into the primary care payment. Services that are not routinely performed in primary care settings or by primary care clinicians should not be incorporated. End-stage renal disease (ESRD) services are not performed by PCPs. A PCP coordinates non-ESRD care and should be able to report an APCM service for a patient receiving ESRD services as the primary care practitioners still play a role in the care of the beneficiary. Remote monitoring is atypical for the average patient; when it is used, the cost of furnishing that monitoring should be recognized and paid separately. We hope that CHI, PIN and PIN-PS services will be widely available and part of advanced primary care in the future, but until that is the case separate payment will stimulate their adoption. We also recommend that CMS adopt a methodology similar to the APCM codes to recognize the same type of comprehensive longitudinal care furnished by Integrated Behavioral Health practices.

Transformative initiatives have a greater impact when all payers participate. Multi-payer participation is especially important as many primary care practices see a range of patients (unlike geriatrics practices for which Medicare is dominant) and because fee-for-service Medicare is no longer the majority payer for Medicare beneficiaries. CMS should look for opportunities to initiate APCM payment methodologies in Medicaid waivers. We believe this new payment model is so closely aligned with care coordination and excellent primary care that Medicare Advantage plans that do not adopt these codes are not providing the same benefit to their members that is available under traditional Medicare. Therefore, absent an alternative equivalent method of recognizing and supporting advanced primary care, these services should be required to be covered and paid in Medicare Advantage.

B. Billing Requirements

Component Summary: CMS notes lessons it has learned from Innovation Center initiatives, including that retrospective reconciliation or adjustment of payments for services rendered is extremely frustrating for practitioners and reduces the predictability and stability of payments. CMS asks about reducing the burden of billing for population-based and longitudinal care services. CMS specifically asks about the appropriate episode length for a primary care bundle and whether payment should be made to a single clinician or weighted for attribution and payment to multiple clinicians and how the primary clinician would be identified. CMS also asks if there should be restrictions on the types of non-physician clinicians that can bill an APCM type bundle and what should occur when a bundle is reported but another entity reports a primary care service. CMS asks about which services should be excluded from the bundle. CMS also asks whether beneficiary coinsurance has caused a barrier to furnishing care management services and whether there are health information technology (IT) functions that should be required for an advanced primary care bundle.

AGS Response: The AGS agrees with CMS about the importance of minimizing administrative burden under advanced primary care models. As CMS recognizes in this RFI, primary care specialties are already doing much of the hard work of delivery system transformation through participation in different payment models. We have tested numerous different payment mechanisms and adapted to extremely specific reporting requirements. We strongly agree that retrospective reconciliation is not an effective means of supporting primary care. Such mechanisms typically rely on historical spending and on risk adjustment factors that are designed for other purposes. Payments that are subject to retroactive reconciliation do not provide a consistent and predictable source of funding that can be used to invest in improvements in practice capabilities. CMS should not adopt such payment methodologies in future advance care payment models.

CMS should also avoid complicated attribution models that assert that any physician who is furnishing a high volume of services is furnishing primary care. Primary care is not based on the number of services furnished but rather on the type of care provided. The NASEM report defined high quality primary care as: "the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."[3] A specialist may provide a high volume of services related to a specific condition, but not furnish primary care because the specialist is not accountable for other conditions that the patient may also have.

CMS should make dedicated payments to primary care practices who are furnishing comprehensive, longitudinal care. **Only one practitioner/practice is the PCP** and only those correctly classified as PCPs are plausibly the "primary care" practitioner. CMS could identify practitioners who are providing primary care by looking at billing patterns for services that would likely only be furnished by PCPs such as the Annual Wellness Visit (AWV). Practitioners for whom claims for the

[3] NASEM report, p. 4

AWV are a specified minimum percentage of the total services furnished could be designated as PCPs and those practitioners would be eligible to receive advanced primary care payments. Provision of services that might be furnished as part of primary care or as part of other care that does not meet the definition of primary care, such as E/M visits, should not be used to identify eligible PCPs.

Beneficiaries could then be attributed to primary care practices associated with individual PCPs. Attributing beneficiaries at the practice level is appropriate because the advanced primary care payments are meant to support practice-level improvements and capabilities. It will also help reduce the need to reassign patients due to changes in employment, such as practitioners relocating or retiring.

Accurate attribution is critical to achieving the goals of a transformed primary care system. Any disconnect between the patients attributed to a practice and those actually receiving comprehensive, longitudinal care from the practice undermines the integrity of the program. Erroneous attribution means practitioners are held accountable for care they are not managing. It also may result in failure to pay for care management services that are being furnished or payment for care management services that are not furnished. The proposed APCM payment methodology adroitly and efficiently addresses these questions. CMS defines the capabilities that must be maintained to be considered an advanced primary care practice. By reporting APCM services, the practice is attesting to this status. The practice is obligated to obtain consent, so the beneficiary must concur with the designation.

We provided comments above regarding excluded services. Here, we address when another clinician provides and reports a primary care service. First, by not bundling E/M visits, CMS can reduce the number of instances when this might occur. CMS should not adopt the flawed methodology used under Primary Care First to address this concern. Under Primary Care First, primary care practices are penalized when a beneficiary receives services included in the bundled per beneficiary payment from another practitioner. Advanced Care Planning (ACP) is one of the services included in the per beneficiary payment. If an oncologist discusses care goals and reports an ACP service, the primary care practice is penalized. In addition, if a patient is referred outside of their practice to a practitioner in a primary care specialty the primary care practice is penalized. Geriatricians are considered primary care clinicians, which they are for many patients, but not all. If a patient is referred by their PCP to a geriatrics and/or palliative care specialist, the PCP practice is penalized, but not if they seek specialist care from a cardiologist or other specialty. Almost all advanced practice registered nurses (APRNs) are considered primary care but these clinicians are playing an ever-increasing role in supplementing the specialty physician workforce. Any referral to a specialty practice that uses APRNs potentially results in a penalty. The result is that some primary care practices effectively receive almost no supplemental payments to sustain the care team because of these penalties.

We recommend an episode duration of one month. Advanced primary care is a continuous service and monthly episodes balance the need for consistent payment for this care without creating long periods of nonpayment or overpayment for services. It also provides predictable opportunities to recognize any changes in beneficiary status such as changes in PCPs.

The AGS is an interprofessional society that believes deeply in team-based care, and we recognize the importance of NPPs to the primary care workforce. Any NPP that is furnishing advanced primary care should be able to report APCM services. However, just as we do not believe specialists perform primary care, we do not believe specialist licensure classes provide primary care. With the exception of geriatrics and gerontology, specialized NPPs such as psychology or behavioral health APRNs (CNS) should not be allowed to report APCM services.

The current health IT requirements of the proposed APCM codes are sufficient. It can be argued that health IT has plagued primary care as much as it has benefited it. We look to CMS to improve certification requirements and to reduce quality reporting burdens or potential inaccuracies created by eCQMs or dQMs.

Finally, the AGS believes that beneficiaries should not pay coinsurance for advanced primary care services. These services are intended to be population-based and are an investment in the Medicare program and the US healthcare delivery system as a whole. Research shows that healthcare outcomes and costs in the U.S. are strongly linked to the availability of primary care physicians. According to the 20th report of the Council on Graduate Medical Education on Advancing Primary Care, studies have found that patients with access to a regular primary care physician have lower overall healthcare costs than those without one as well as improved health outcomes.[4] The capabilities and practices that are part of advanced primary care will benefit Medicare and its beneficiaries but will also benefit other patients in those practices and the payers who contract with them. Certain Medicare beneficiaries should not have to pay 20 percent of those costs while other patients and payers pay nothing.

C. Person-Centered Care

Component Summary: CMS describes person-centered care as integrating individuals' clinical needs across providers and settings, while addressing their social needs as we strive for more affordable care and improved health outcomes. CMS asks about how to structure advanced primary care payments to support the delivery of coordinated care, improve patient experiences, and ensure appropriate access to telephonic and messaging primary care services. CMS asks how to best achieve efficiency and to promote high-value care. CMS also asks about the best reporting structure to ensure targeted services are delivered without causing undue or excessive documentation and how to facilitate coordination between PCPs and specialists.

AGS Response: AGS supports team-based care including behavioral health integration. We also support incentivizing increased communication to support coordination of care for patients and their caregivers. These services, such as care management and inter-professional consultation referrals, often involve complexity in tracking and billing that make fee-for-service payment difficult. We recommend that payment for those services be part of a capitated amount that allows flexibility in who furnishes the services and how, as CMS has proposed. The capitated payment should include

[4] Council on Graduate Medical Education (COGME). Twentieth Report to Congress: Advancing Primary Care. 2010: Available at http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf.

additional support for a broad array of services and staff that have no billing codes. For example, the typical in-box of the primary care practitioner often approaches 100 items a day; a specialist who has limited care coordination obligations does not have this issue. Capitated payments should incentivize caring for the population efficiently, using team members and non-visit care when appropriate. However, a capitated payment based on historic spending is insufficient to transform a practice. Sustained supplemental payments are needed to hire and maintain the team, supported by a meaningful increase in spending for primary care to achieve the policy objective of increasing access and improving public health.

Primary care practices do their best to discuss patient goals and what matters most to patients. This focus appropriately reduces specialty and facility costs associated with the care of many patients. However, AGS is unaware of a method that effectively engages specialists or facilities.

We believe the proposed APCM payments balance expectation, requirements and administrative simplicity. It is imperative that these codes and payment be efficiently and effectively implemented. In our comments on the proposed rule, the AGS recommended that CMS make the process for confirming that a practice has the required capabilities as simple as possible. Potential APCM practices, particularly those that are geriatrician led, have been providing many of the APCM services gratis for years while watching their practices be unable to recruit new clinicians or sustain themselves. Those practices should not be subjected to burdensome documentation in order to bill for the new codes which are intended to help ameliorate this situation. The best way for CMS to structure payments to improve access, experience and outcomes is to adequately pay for primary care. Without primary care the triple aim of improving patient experience of care, improving population health and reducing per capita costs of health care will not be attainable.

D. Health Equity, Social and Clinical Risk

Component Summary: CMS asks for input on how advanced primary care billing and payment policy could be used to reduce health disparities and social risk and how to ensure that any risk adjustment method applied to advanced primary care payments incentivizes the appropriate coding of patient conditions and needs, including those that have previously been under-documented, such as dementia and patient frailty. CMS asks about non-claims-based indicators that could be used to improve payment adequacy, specific risk factors that should be considered in developing payment rates, and risk adjustments that could account for higher costs of traditional underserved populations. CMS also asks about accounting for changes in coding patterns rather than health status and steps CMS can take to ensure that advanced primary care coding and billing is utilized for dually eligible beneficiaries and safety net providers. CMS asks about including newly recognized health equity services of CHI and PIN in the bundle. CMS asks what to do for those who lack a usual source of care. CMS also asks what metrics should be considered to assess potential worsening disparities.

AGS Response: Risk adjustment can be an important part of primary care payments, if it is applied appropriately and accurately. AGS appreciates the relatively straightforward stratification of patients under the proposed new APCM codes which pay differentially based on the number of chronic conditions and whether or not a patient is a Qualified Medicaid Beneficiary (QMBs). We believe that this approach

has numerous benefits including being predictable and appropriately identifying the most complex patients (those with multiple conditions and QMB status).

More complicated risk adjustment would be particularly important for geriatrics practices if CMS were to consider a single payment amount for advanced primary care services. Most non-geriatrician PCPs will have a significant Medicare panel size as well as a typical mix of patients with other payers, and therefore, an average may work for these practices. However, this would be devastating for the typical geriatrics practice which is comprised almost exclusively of the most complex and frail Medicare beneficiaries. Risk adjustment will be necessary to ensure that geriatricians are paid appropriately for serving this population.

It may be necessary to develop a specific risk adjustment methodology for primary care that could include other factors such as the Area Deprivation Index (ADI) to better recognize the greater costs of providing excellent care to a disadvantaged population. This is not claims-based. The most commonly used adjuster is the claims-based hierarchical condition category (HCC) risk factor but HCC adjustments are more commonly associated with prediction of total costs, not specifically primary care costs. Diagnosis-based risk adjustment may be insufficient to fully capture all the relevant factors and it may be necessary to include other elements such as functional characteristics. Other elements may affect the cost of furnishing advanced primary care including the optimal setting for individual patients. For example, primary care may best be furnished in the home for some patients and home services are more costly to provide than an office visit.

Payers and scientists are all working on methods to recognize risk based on social vulnerability and non-diagnosis factors. This is a science and CMS should continue to invest in understanding methods to better refine risk-adjustment. In the proposed rule, CMS created a simple 3 level methodology that we believe is likely to promote equity and recognize different costs of care based upon the number of conditions. This approach does not rely on adjusters such as HCCs and therefore also does not promote HCC code “creep” or require the primary care clinician to become a diagnosis coding expert. Reporting functional status would be an additional burden on PCPs, but it could be built into APCM definitions such as establishing a tier that lists functional dependency as a chronic condition or equivalent to QMB status. This approach would also incentivize practitioners to assess function and performing AWVs.

We believe that CMS proposals to carry through APCM payments to FQHC and RHC will promote equity and access and make it possible for patients who seek a source of routine care to have one. As previously stated, we believe that separate payment for CHI and PIN promotes equity and development of these services, especially as the patients who need them are not evenly distributed across all practices. We believe clear guidance on APCM requirements and education will stimulate the use of APCM services by all practitioners, but agree that directed outreach to safety net providers may be helpful.

If care improves for all, but less so for the disadvantaged, this is a partial victory and should be viewed as such while the cause of any disparity is assessed and addressed, if possible. We appreciate that patient satisfaction surveys are costly, but we have historical data collection by our public health systems and philanthropic organizations that look at access to care. These as well as emergency department usage rates, nursing facility (not SNF) admission and other measures of days in the community may be useful in evaluating the impact of the APCM program. It is important that these measures be used for evaluation of the program and not applied to individual practices.

We also ask CMS to consider how best to support practitioners serving Medicare's sickest and most complex patients. One option we would recommend is for CMS to integrate beneficiary identification into the payment methodology for APCM services so that if a practice submitted an APCM code for a less complex patient and CMS determines that the patient is a QMB, then the claim would be paid at the highest level. This will ensure that claims for APCM are paid correctly.

E. Quality Improvement and Accountability

Component Summary: CMS wants practitioners who bill for advanced primary care payments to be engaged in a relationship where they are responsible for the quality and cost of care of the beneficiary as part of its ultimate goal of having every person with Traditional Medicare be in an accountable care relationship in 2030. CMS asks about key patient-centered measures of quality, outcomes and experience that would help ensure that hybrid payment enhances outcome and experience for patients or that could guard against any decrement in access or quality.

AGS Response: AGS believes that advanced primary care payments will help advance CMS' 2030 goal for accountable care relationships because such payments will help ensure the continued viability of primary care practices and ameliorate financial disincentives for new practitioners to enter primary care. Without such improvements, there will be insufficient practitioners to meet CMS' goal in a meaningful way, where beneficiaries are receiving high-quality primary care. As previously stated APCM is complementary to accountable care and MSSP and other models retain benefits for delivery system participants.

Advanced primary care payments should be associated with a measure that validates that the care furnished was goal-directed in accordance with what matters most to the beneficiary. In terms of additional measures CMS should consider, a single structural measure such as recognition as an Age Friendly practice[5] which may do more to positively transform care than numerous complicated measures.

We also briefly address other questions. Using measures that are already part of MSSP or the Quality Payment Program significantly reduces the administrative burden on practitioners. It is important that new clinicians are able to report APCM codes even if they are not yet MIPS eligible. It is difficult to report some measures across populations – Medicare compared to commercial – because the populations are different. CMS should not adopt 5 Star metrics to align with Medicare Advantage as these metrics are not appropriate at the practice level and create significant burden and frustration when plans push them down to the practice. Some disease specific or prevention metrics have utility, e.g. control of hypertension, diabetes and colorectal cancer screening, if exceptions for limited life expectancy are included. Reporting of APCM services should not be conditioned on accepting risk. We do not know what accountability may be considered for further burden reduction, but we do not see the proposed APCM methodology as being burdensome and "accountability" measures are likely to be a burden. We also believe the current practice requirements are well calibrated to the current

[5] Institute for Healthcare Improvement. "Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults" (2020).

state of primary care and will advance the work of APCM ready practices while incentivizing others to reach this level.

However, CMS should be cautious in the adoption of new measures and avoid using unnecessary or unproven measures. Any new measure takes a significant amount of time for practices/providers to implement. Practices must develop internal processes in order to understand current performance and identify ways to improve. EMR systems and standards often must be modified. Clarity on attribution and feedback on performance is essential for a measure to meaningfully affect change. All of these elements add administrative burden and cost to the system. If a measure has not been shown to improve access to high quality care for beneficiaries, then resources should not be dedicated to implementing the measure.

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The transition from inadequate fee-for-service payments for primary care to a hybrid method that supports interprofessional team based comprehensive primary care is essential. We believe implementation, when done correctly, will be acceptable to most stakeholders, whether beneficiary, PCP, specialist or other health care delivery entity. We commend CMS for their proposed transformative and landmark proposal.

The AGS appreciates CMS' thoughtful presentation of the issues under consideration and looks forward to continuing to work with CMS to improve recognition of and payment for advanced primary care. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,

Mark Supiano, MD
President

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Chief Executive Officer