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The Honorable Kim Schrier, MD
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Re: Feedback on Stabilizing the Medicare Payment System

Dear Representatives Bera, Bucshon et al.:

The American Geriatrics Society (“AGS”) greatly appreciates the opportunity to provide feedback on the actions Congress can take to stabilize the Medicare physician payment system while continuing to incentivize patient-centered, value-based care. The mission of the AGS, a nationwide not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (“NPPs”), is to improve the health, independence, and quality of life of all older adults. Our members are pioneers in advanced-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 believes increased payment accuracy for physicians and other professionals paid under the Physician Fee Schedule (“PFS”) and through the Quality Payment Program (“QPP”), established by the Medicare Access and CHIP Reauthorization Act (“MACRA”) is a cornerstone to improving access to care in rural and historically minoritized communities. AGS is actively engaged in efforts to advance value-based, high quality care for older Americans, and we appreciate Congress’ willingness to listen to our concerns and experience with these programs.

Need for Immediate Congressional Action

As Congress considers long-term solutions to stabilize the Medicare physician payment system, we urge Congress to address the impending payment reductions set to take effect on January 1, 2023. Absent Congressional action, these Medicare payment cuts, if enacted, will impede patient access to care. Before the end of the year, we strongly urge Congress to:

- Provide relief from the scheduled -4.42 percent budget neutrality cut in Medicare physician fee schedule payments;
- End the MACRA mandated annual freeze to the Conversion Factor and provide a Medicare Economic Index (“MEI”) update for the coming year;
- Extend the 5 percent APM participation incentive payments for six years by enacting H.R. 4587, the Value in Health Care Act, as well as halt the revenue threshold increase, which will have a chilling effect on participation, to encourage more clinicians to transition from fee-for-service into APMs;
- Waive the 4 percent Medicare cuts associated with the Statutory PAYGO sequester triggered by passage of the American Rescue Plan Act; and
- Amend the current statutory authority for budget neutrality adjustments by requiring a look-back period that allows the Centers for Medicare & Medicaid Services (“CMS”) to correct for overestimates in utilization and thereby return inappropriately reduced funding back to the payment pool.

AGS Recommendations for Long-term Solutions

MACRA was based on replacing the unworkable cost control mechanism of the Sustainable Growth Rate (“SGR”) with a new payment system that was intended to incentivize value-based care. However, like the SGR system before it, MACRA—particularly the provisions establishing the Merit-Based Incentive Payment System (“MIPS”)—focused on “accountability” that largely is siloed by individual disease state/condition, disproportionately focused on performance and payment at the individual clinician and individual specialty level, and by virtue of the budget neutrality of the incentive payment structure picks clinician “winners” and “losers.” We cannot achieve the promise of value-based care with this fragmented approach, which focuses on rewarding high “performers” rather than encouraging a better healthcare delivery system, one that serves all individuals regardless of where they live, their socioeconomic status, and the color of their skin. A high-quality, cost-effective healthcare system results from care that is person-centered, team-based and grounded in strong primary care — the payment system must reflect, reinforce, and incentivize this type of care.

Specifically, the AGS believes that truly value-based care requires:

- Multi-disciplinary teams of physicians and non-physician practitioners caring for patients, with the primary care practitioner central to facilitating care coordination.
- Strong primary care, as envisioned in the report of the National Academies of Science, Engineering and Medicine: “Implementing High Quality Primary Care,”¹ with meaningful

¹ 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.

education for beneficiaries on the importance of every person having an established source of primary care.

- A whole-person orientation with input from patients and their families, where areas of quality measurement focus on the total cost of care and patient-oriented outcomes rather than condition-or specialty-specific.
- An intentional commitment to equitable care and reducing disparities by, among other strategies, financially supporting organizations embedded in underserved communities, including rural and urban Health Professional Shortage Areas, and providing financial incentives for care management services, particularly to historically minoritized and rural communities (e.g., support for self-care or navigating complex health systems). Importantly, the payment system must not financially “punish” those who care for communities with less advantage or people with greater complexity.
- A regulatory, payment, and technological framework that permits providers flexibility to establish practice organizations that are best for the people they care for and that addresses existing financial, legal, and regulatory burdens that have led to the rapid consolidation and monetization of healthcare in the United States. Nearly three-quarters of U.S. doctors work for corporate entities such as private equity firms, health insurers and hospitals in 2022, up from 69 percent in 2021.² Rather than driving system efficiencies and savings, studies show that private equity acquisitions of physician practices are associated with increased healthcare spending and patient utilization, with the average charge per claim increasing 20 percent and the average allowed amount per claim up 11 percent post-acquisition.³
- Accessible care settings for people, including care that is accessible to patients in their homes through telemedicine and programs such as “hospital at home” and “Independence at Home,” when clinicians deem it appropriate.
- Administrative expertise and analytic support for clinical teams, with an overall goal of reducing administrative burden, so that clinicians can both maintain focus on care and still have ownership and involvement in quality measurement (and prevent unnecessary consolidation of physician practices).
- Electronic health information exchanges and electronic health records (“EHR”) systems that are helpful, not a hassle, and that easily permit patient information to be shared across different entities that care for the patient to support clinical decision-making and care coordination, and mitigate patient risk and waste (including through use of data-driven tools that take advantage of artificial intelligence technologies).
- Both stability and flexibility whereby investments in value-based care transformation can be confidently made, but with enough flexibility to correct for the inevitable miscalculations and missteps inherent in any change.
- Greater diversity in the health care professions through more reasonable cost of education and greater consideration of programs like the National Health Services Corps.

² Physicians Advocacy Institute, COVID-19’s Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021, a study prepared by Avalere Health, April 2022, http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZflmFdXlvGg%3d%3d.

³ Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum*. 2022;3(9):e222886. doi:10.1001/jamahealthforum.2022.2886.

- Payments that include:
 - Incentives that are generally positive, but there may be limited negative incentives for maintaining the fee-for-service *status quo*.
 - Reasonable payment updates that reflect changes in the cost of providing care as well as inflation. Adjusted for inflation in medical practice costs, as measured by the MEI, Medicare physician payment rates declined 20 percent from 2001 to 2021.

The AGS believes that these are attainable goals and ones that must be reflected in any legislative effort that considers changes to MACRA, incentives for adoption of alternative payment models (“APMs”), and the future of physician payment more generally. It is also critical that Congress recognize that the long term vision of developing a better performing health care system at times may be in tension with saving Medicare dollars in the short run. Congress should not preoccupy itself with short-term savings to the detriment of long-term goals. Like any institution seeking transformation, we must be willing to make upfront investments in order to achieve long term efficiencies and quality improvements.

With these goals in mind, we recommend that Congress take a holistic approach to reviewing physician payment under Medicare. At a minimum, Congress must establish a stable, annual Medicare physician payment update that keeps pace with inflation and practice costs and allows for innovation to ensure Medicare patients continue to have access to multi-disciplinary team-based care across specialties.

Finally, we would like to emphasize the need for CMS to have the flexibility to improve design and implementation over time and in response to actual performance of the program. The statutory provisions underlying these programs should afford CMS with adequate authority to adapt, taking into consideration the Supreme Court’s recent ruling in *West Virginia v. Environmental Protection Agency*.⁴

Below, we address your specific questions in the September 8, 2022 Request for Information.

1. Effectiveness of MACRA

MACRA has made great contributions to transforming healthcare, but has many flaws in its design and limits on what it can currently achieve. Eliminating the unfair and unsustainable SGR was in itself a major contribution of this legislation. Additionally, MACRA has greatly advanced APM development, growth, and adoption. Certain APMs, such as Accountable Care Organizations (“ACOs”) and patient-centered medical homes (“PCMHs”) offer great promise, showing improvements in quality as measured by the current methodology and contributed to reduced spending. In 2021, ACOs generated approximately \$190 net savings per attributed beneficiary, with \$1.6 billion in savings overall -- the fifth year in a row ACOs generated savings for Medicare -- with 99 percent of all ACOs meeting quality standards.⁵ Similarly, PCMHs have been shown to achieve better health outcomes, more health equity, and lower costs. For example, the 2019 Evidence report from the Patient Centered Primary Care

⁴ *W. Virginia v. Env't Prot. Agency*, 213 L. Ed. 2d 896, 142 S. Ct. 2587 (2022), available at https://www.supremecourt.gov/opinions/21pdf/20-1530_n758.pdf.

⁵ "Performance Results Of The Medicare Shared Savings Program In 2021: Continued Uncertainty With Positive Movement", *Health Affairs Forefront*, October 20, 2022. DOI: 10.1377/forefront.20221019.98329

Collaborative found that as primary care investment increased, both hospital outcomes and emergency department visits decreased, ultimately resulting in cost savings.⁶ More significantly, these APMs have fundamentally changed the manner in which many entities, from single clinicians to large healthcare systems, view and approach health care—putting the patient at center and being good stewards of resources in promoting health of the population.

Despite their promise, adoption of APMs remains too low and appears to be stagnating. The percentage of health care payments tied to APMs has slowly increased over the past years from 35.8 percent in 2018, to 38.2 percent in 2019, and to 40.9 percent in 2020.⁷ As discussed in more detail below, we believe the Advanced APM bonus should be extended to continue to encourage adoption of APMs, but Congress should change the definition of an eligible APM to incorporate a broader group of APMs, including those that take on “one-sided” financial risk because of the substantial investment risk that is taken.

In contrast, the MIPS program has had minimal impact given some fundamental flaws in its design and limits on its effectiveness to incentivize high-quality, cost-effective care. Specifically, the budget neutral structure results in a zero sum game that establishes individual winners and losers based on their purported performance on measures that are largely condition specific. For example, in 2020, 2 percent of eligible clinicians received a negative payment adjustment, 2 percent were neutral, 11 percent positive, and 85 percent exceptional.⁸ This corresponds to 2022 payment adjustments of -9 percent - 0 percent for negative, 0 percent for neutral, 0 percent - 0.01 percent for positive, and 0.12 percent - 1.87 percent increased payment adjustment for exceptional.⁹ In comparison, the 2023 MIPS payment adjustments vary between -9 percent and +2.33 percent for negative payment adjustments through exceptional.¹⁰ Although the payment adjustments for exceptional have increased, the performance threshold and changes in weight to quality and cost performance categories will make it more difficult to achieve higher ratings.¹¹ Coupled with an expected increase in clinician participation means more clinicians sharing the budget neutral pool and thus lower payment adjustment percentages in the future.¹²

Moreover, as it stands, information from episode-based cost measures and quality measures are not particularly actionable because each is limited to a particular condition and snapshot in time rather than a holistic view of resource use and quality of care for the individual or a population. Additionally, attribution and reporting periods for cost measures and quality measures differ, making it difficult to assess how these two important components of value-based care are interacting with each other. This type of program design is doomed to fail at incentivizing system-wide improvements in the quality and

⁶ Patient Centered Primary Care Collaborative, Investing in Primary Care A State-Level Analysis, July 2019, https://www.pccpc.org/sites/default/files/resources/pcmh_evidence_es_2019.pdf.

⁷ Healthcare Payment Learning & Action Network (“HCP LAN”), As progress continues in alternative payment model adoption, the LAN launches new initiatives and guidance to accelerate action for value-based payment reform, December 2021, <http://hcp-lan.org/workproducts/2021-APM-Progress-Press-Release.pdf>.

⁸ CMS, Quality Payment Program Participation In 2020: Results At-A-Glance, <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1783/QPP%202020%20Participation%20Results%20Infographic.pdf>.

⁹ *Id.*

¹⁰ MD Interactive, Faqs About The MIPS Feedback Reports And Payment Adjustments, <https://mdinteractive.com/mips-feedback-reports#:~:text=The%202023%20MIPS%20payment%20adjustments,9%25%20and%20%2B1.87%25>.

¹¹ <https://blog.healthmonix.com/2021-final-rule-new-programs-higher-standards-covid-19>

¹² 85 FR 84472, <https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>

cost-effectiveness of care. Instead, the program needs to be re-designed to incentivize coordinated, high-quality care, efficient care. As noted above, high-value healthcare requires teams, systems and whole person care. The multi-morbid beneficiary is the most expensive beneficiary and the one most likely to benefit from care coordination, teams in primary care (with integrated behavioral health), improved transitional care and cross specialty coordination.¹³¹⁴

2. Regulatory, Statutory, and Implementation Barriers to MACRA Fulfilling its Purpose of Increasing Value in the US Healthcare System

The first barrier to address is the statutory construct (as well as regulatory implementation) of MIPS that has rendered the program ineffective. The program is overly complex, contains an enormous volume of measures and conditions that look at fragmented pieces of care rather than the whole person, and results in reporting that is disconnected from actual practice. Indeed, keeping abreast of the detailed program requirements across the four performance categories and countless measures, which change and evolve every year, is nearly impossible unless clinicians engage experts to manage reporting on their behalf. This redirects limited resources to administrative activities that do not directly improve care and distances the actual clinicians from any sense of personal investment in MIPS. In other words, time, talent, and money are largely wasted on activities that do not achieve system redesign or improve care.

Unfortunately, these financial and administrative burdens have hastened consolidation and a venture capital approach to care to the detriment of patients. Moreover, to the extent that measure reporting theoretically helps incentivize efforts to improve processes and outcomes or reduce cost, the small financial incentives resulting from budget neutrality make the administrative burdens, which are significant, not worth the effort, as further addressed in the recommendations below.

3. Recommendations to Improve MIPS and APM Programs

Refocus the Program to Move Almost Exclusively to APMs. Today, to avoid a negative adjustment to their payments and despite its limited utility, approximately 89 percent of clinicians participate in MIPS rather than Advanced APMs.¹⁵ For the reasons described above, the AGS believes that ideally MIPS should be eliminated except in rare circumstances and APMs should be made more accessible to clinicians. Additionally, Congress should extend APM incentives while simultaneously encouraging CMS and the Center for Medicare and Medicaid Innovation (“CMMI”) to refine and improve the APMs that show the greatest promise. Here, we describe such a glide path to APMs, but in the absence of such changes, we also present recommendations below for improving the existing framework.

We believe that MIPS, a relic of prior quality reporting programs, has served its limited purpose in generally providing clinicians with a greater awareness of quality and cost considerations related to

¹³ McNabney, MK, Green, AR, Burke, M, et al. Complexities of care: Common components of models of care in geriatrics. *J Am Geriatr Soc.* 2022; 70(7): 1960- 1972. doi:[10.1111/jgs.17811](https://doi.org/10.1111/jgs.17811)

¹⁴ American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. Guiding principles for the care of older adults with multimorbidity: an approach for clinicians. *J Am Geriatr Soc.* 2012; 60(10): e1- e25. doi:[10.1111/j.1532-5415.2012.04188.x](https://doi.org/10.1111/j.1532-5415.2012.04188.x)

¹⁵ CMS, Quality Payment Program (QPP) Participation In 2020: Results At-A-Glance, reported 2021, <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1783/QPP%202020%20Participation%20Results%20Infographic.pdf>.

care. Accordingly, the statute should be amended to make MIPS a transitional program [that will sunset by a certain date], except for the rare clinician who, given their specialty or location, cannot reasonably participate in an APM. For this narrow group, MIPS may be extended, but significantly simplified and better targeted toward the characteristics of the clinicians remaining.

All other clinicians should be incentivized to participate in APMs, with clear deadlines for joining an APM (or eventually face penalties or the absence of updates or incentives). Over time, the current trends in professional employment and such legislative and regulatory steps will result in more individuals moving to health care organizations that participate in APMs.

Most importantly, incentives to participate in an APM (i.e., the Advanced APM bonus) should be modified and extended to support investments in delivery system redesign. In particular, and as discussed in more detail below, the definition of Advanced APM should be modified statutorily to remove CMS's regulatory requirement that an Advanced APM take on a certain percentage of downside payment risk. With the potential elimination of MIPS and uptake in APMs, such incentives will be critical.

We recommend a grace period of 1-2 years for new clinicians that permits, but does not require, their participation in MIPS or APMs. Clinicians early in their careers may inherit "attributed" patients over whose prior care they had no control, and we believe it is unfair to potentially expose them to negative payment adjustments based on care that they did not themselves provide on top of being saddled with significant educational debt.

If MIPS is Phased Out, Reallocate MIPS Administrative Resources to Address Underlying Impediments to Value-Based Care. Congress should consider reallocating current MIPS administrative resources to address broader health system issues that undermine the high quality, cost effective care envisioned in MACRA, such as EHR interoperability and other issues and solidifying state/cross state/federal public health reporting systems. Attempting to improve these information systems indirectly through incentive programs focused on providers is inefficient at best, and likely fruitless if underlying issues make their utilization burdensome and unuseful. Instead, such efforts should be redirected to improving the underlying tools. In the last decade, there have been significant increases in adoption and use of EHRs, in part due to the EHR Incentive Programs and MIPS. For example, office-based physician EHR use has jumped from 22 percent in 2009 to 72 percent in 2019.¹⁶ There remain, however, fundamental issues with current EHR systems that present a major barrier to positive transformation that will not be addressed by simply continuing to require individual clinicians and groups to report EHR-based measures. Those issues include, extreme costs, lopsided power dynamics of the electronic medical record ("EMR") industry, the lack of human factor design, interoperability and other defects, which among other things create barriers to data collection and information sharing, undermine team-based, coordinated care, as well as efforts to develop independent practice associations ("IPAs") to manage risk in lieu of consolidation. The 21st Century Cures Act attempts to address some of these issues by addressing data blocking.¹⁷ However, Congress should do more to

¹⁶ Office of the National Coordinator for Health Information Technology. 'National Trends in Hospital and Physician Adoption of Electronic Health Records,' Health IT Quick-Stat #61. March 2022.

¹⁷ 45 CFR 171.103(a). Data blocking refers to interference with the access, exchange, or use of electronic health information without special effort on the part of the user except as required by law.

facilitate interoperability and improve usability of certified EHR technologies, which are akin to public utilities. Market forces alone will not do this.

Additionally, the COVID-19 pandemic has exposed the inadequacies of our country's health information exchange apparatus, including the ability of providers to send information to, and receive information from, public health agencies (e.g., public health registries and immunization registries and for syndrome surveillance and case reporting). For example, during the early stages of COVID-19, the lack of IT system interoperability caused health officials and their key stakeholders (e.g., hospitals) to manually input data into multiple systems. In addition, some state health departments could not directly exchange information with CDC via an IT system. This led to longer time frames for CDC to receive the data they needed to make decisions on the COVID-19 response.¹⁸ While the CARES Act facilitated important investment in improving information exchange related to vaccinations, Congress could do more to help improve state and federal public health reporting infrastructure. For example, three years into the pandemic, the same inadequate data systems hampered the response to the monkeypox outbreak.¹⁹

Improvements to MIPS. To the extent MIPS is maintained, the program should be further analyzed to improve it. Specifically, we recommend that CMS or ASPE conduct an analysis to determine whether there is evidence that MIPS as a whole, or with respect to particular performance categories, has resulted in improvements in quality of care or more efficient use of healthcare resources. Currently, there is a lack of clear data analyzing what is working (and therefore should be retained) and what is not. However, such research should not delay areas where there is obvious need for reform. Therefore, the AGS recommends:

- Simplifying reporting by dropping Improvement Activities, reducing the number of measures that must be reported, and moving toward measures that can be calculated through existing processes (e.g., EHRs, claims-based population measures) without extra work by clinicians.
- Improving attribution for cost measures through explicit attribution and patient relationship codes.
- Evaluating primary care clinicians on total cost measures rather than by chronic condition episode-based measures and similarly providing feedback around total resource use. However, it is critical that such measures are appropriately risk-adjusted so that clinicians do not avoid caring for the sickest patients or people who are economically disadvantaged. Further measures must account for the fact that the cost for certain items and services, such as high-cost Part B drugs without generic alternatives or biosimilars, are outside of the control of clinicians.
- Harmonizing cost and quality measure reporting periods (i.e., ensure that quality measures run over the same reporting period as episode-based cost) so that they apply to the same population over the same time period and, therefore, provide a more comprehensive view of the value of the care provided.
- Continuing to refine risk-adjustments and retaining the complex patient bonus.

¹⁸ US Government Accountability Office (GAO), Public Health Emergencies: Data Management Challenges Impact National Response, September 2022, <https://www.gao.gov/products/gao-22-106175#:~:text=During%20the%20early%20stages%20of,CDC%20via%20an%20IT%20system.>

¹⁹ See, LaFraniere, Sharon, 'Very Harmful' Lack of Data Blunts U.S. Response to Outbreaks, New York Times, September 20, 2020, <https://www.nytimes.com/2022/09/20/us/politics/covid-data-outbreaks.html>.

- Creating avenues for establishing organizations that can assume responsibility for the cost of care, without requiring corporate consolidation or private equity investment (e.g., IPAs). This can help support, for example, solo practitioners, small independent practices, and clinicians practicing in rural communities.

4. Increasing Provider Participation in Value-based Payment Models

AGS supports continued efforts to reduce barriers to, and provide incentives for, participation in APMs. Below, we provide a number of recommendations regarding how to achieve broader engagement with APMs:

Extend the Advanced APM Bonus for Future Years and for a Broader Set of APMs. If Congress wishes to incentivize APM uptake, maintaining and expanding the 5 percent bonus is critical. **We urge Congress to pass H.R. 4587, the Value in Health Care Act**, which would extend the Advanced APM incentive payments created under MACRA for an additional six years and authorize the Secretary to set the revenue threshold for clinicians to be eligible for these incentive payments. Absent Congressional intervention, 2022 marks the last year clinicians are eligible to qualify for an APM incentive payment and the associated revenue thresholds jump from 50 percent to 75 percent on January 1, 2023.

We also believe that applicability of the bonus should be expanded to include clinicians that participate in APMs that require entities to take on one-sided financial risk. CMS has required that “eligible APM entities” must potentially owe to CMS or forgo payment from CMS equal to at least either (1) 8 percent of the average estimated total Medicare Part A and Part B revenue of [providers and suppliers in] participating APM Entities (the revenue-based standard), or (2) 3 percent of the expected expenditures for which an APM is responsible under the APM for all QP Performance Periods (the benchmark-based standard).²⁰ Thus, CMS interprets the statutory requirement to only encompass “losses” that could be incurred through either direct re-payments to CMS or withholdings/reductions in payments for services.

It has been the AGS’s position since CMS first finalized this rulemaking that this narrow approach established too high a hurdle, limiting incentives for clinicians to join APMs. Instead, bonuses should be available to clinicians that participate in APMs that take on one-sided risk and otherwise meet the statutory requirements. The gains or losses of the APM entity are a function of both costs that the entity incurs to implement the model and the revenues it receives under the model. Under a one-sided shared savings model, an entity bears financial risk if it incurs costs to implement programs that are designed to reduce Medicare spending, since the provider could fail to qualify for the shared savings payment needed to pay for those costs. For example, if an entity hires or pays for new staff to deliver services to patients under the model, acquires new or different equipment to deliver services, or incurs other kinds of expenses to implement the APM, and those expenses are not automatically or directly reimbursed by Medicare, the entity is accepting financial risk for monetary losses. Thus, practically speaking, one-sided payment risk models are still taking on downside risk in the form of potential investment loss.

²⁰ 42 C.F.R. § 414.1415.

These investments can be quite significant. A 2013 survey by the National Association of ACOs found the average start-up costs for an ACO were approximately two million dollars, and described the associated risks as

Estimates in the published literature of ACO start-up costs have ranged widely, with \$1.8 million estimated by CMS in the draft regulations being the most often quoted. [The American Hospital Association] estimated in 2011 that they would range from \$11.6 to \$26.5 million. The average actual start-up costs of the [survey] respondents in the first 12 months of operations were \$2.0 million with a range from \$300,000 to \$6,700,000. Since savings are slow to flow as a result of data and complex reconciliation process, ACOs will have almost a second full year of operations until their cash flow can be replenished with shared savings from CMS (if any). This means that the average ACO will risk \$3.5 million plus any feasibility and pre-application costs. We estimate that in total, ACOs on average will need \$4 million of startup capital until there is a chance for any recoupment from savings.²¹

The costs have surely only risen with normal inflation since that time.

Finally, there is no evidence that taking downside payment risk actually results in better quality or financial outcomes -- instead, this requirement simply serves as a roadblock to broader APM adoption. For these reasons, we urge Congress to extend the Advanced APM bonus to a broader set of APMs that take on “one-sided” financial risk.

Ensure Flexibility for CMMI Program Expansion. Where appropriate and feasible, CMMI should expand models nationally and such expansion should not be hindered unnecessarily by the governing statute. For example, Primary Care First is an essential program to save, support and transform primary care through greater operating flexibilities and performance-based payments, enabling primary care providers (PCPs) to innovate the delivery of care based on their unique patient population and available resources. Payments are based on patient health outcomes, incentivizing clinicians to spend more time with patients and provide coordinated, comprehensive care.²² High quality primary care programs form the foundation of a high-functioning health system and are key to improving the experience of patients and care teams, as well as population health, and reducing costs.²³ However, Primary Care First is only available in some states. A practice that is willing to improve and transform to advanced primary care should be encouraged and supported. As such, the criteria for model expansion should not create unnecessary barriers to wider model dissemination because they are unduly arduous to meet.

Continue To Improve the APMs, with Particular Focus on the Promise of Accountable Care Arrangements. The Medicare Shared Savings Program (MSSP) and the Primary Care First Model are both forms of “accountable care” arrangements through which providers coordinate the provision of care to

²¹ National Association of ACOs, National ACO Survey, conducted November 2013, Final report January 1, 2014, at 1 (emphasis added).

²² The Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI), Primary Care First Model Options, October 2022, <https://innovation.cms.gov/innovation-models/primary-care-first-model-options>.

²³ National Academy of Medicine, Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021), <https://nap.nationalacademies.org/read/25983/chapter/1>.

a set population with the goal of improving patient and system outcomes and avoiding inefficiencies and examples of successful APMs. Thus, it is not surprising that CMMI has established the goal that, by 2030, all Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care.²⁴ There is still a need, however, for refinement and improvement in APMs so that they are more attractive and feasible for clinicians to join. APMs, particularly those structured as accountable care arrangements, could be improved in the following ways:

- Providing pathways for specialty providers to participate in APMs that coordinate care across specialties. To date, specialist clinicians have not adequately been drawn into APMs. For example, specialty care providers could virtually join organizations that have strong primary care in a manner where shared goals and incentives exist without a common employer. Thus, specialists could be tied virtually to the primary care practices that serve their patients (whether self-referred or professional referred), becoming part of a whole person, total cost of care system. We believe this approach is more likely to drive value-based care transformation than specialty-specific or disease-specific APMs, which would further fragment care and create more administrative burden than they warrant.
- Continuing to focus on addressing the effects of social determinants of health on health disparities to provide more equitable and affordable care to patients.²⁵ This could be carried out through, for example, the provision of bonuses for clinicians and/or entities that provide care to rural and historically minoritized communities or supplemental reimbursement for particular care coordination or navigation activities.
- Incorporating primary care bonuses into programs like Primary Care First.
- Establishing incentives for caring for complex people so that all providers are able to care for such patients without risking lower quality or cost scores, which may not be appropriately risk adjusted.
- Improving patient attribution, including through:
 - Promoting explicit attribution (rather than claims-based attribution) and voluntary empanelment, through for example, the use of patient relationship codes.
 - Better defining the role of non-physician practitioners.
- Continuing to refine risk adjustments for cost measures.

Importantly, as Congress contemplates ways to encourage APM participation and value-based accountable care, we urge you not to delegate these activities to the Medicare Advantage program. Traditional Medicare should remain a strong, viable option to help balance potential market dominance by some companies and to preserve beneficiary choice.

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²⁴ CMMI, Strategic Direction, September 2022, <https://innovation.cms.gov/strategic-direction>.

²⁵ CMS, CMS Framework for Health Equity, Oct 2022, <https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity#:~:text=CMS%20strives%20to%20improve%20our,%2C%20disability%20status%2C%20and%20SDOH>.

The AGS appreciates the opportunity to submit feedback on this important issue. If you have further questions, please feel free to contact Alanna Goldstein, Senior Director of Public Affairs and Advocacy, at agoldstein@americangeriatrics.org or 212-308-1414.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Harper" with a stylized flourish at the end.

Michael Harper, MD
President

A handwritten signature in black ink, appearing to read "Nancy E. Lundebjerg" in a cursive style.

Nancy E. Lundebjerg, MPA
Chief Executive Officer