

June 18, 2024

United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

RE: Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B

Dear Chairman Wyden and Ranking Member Crapo:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to provide feedback to the Senate Committee on Finance on its May 17th white paper “Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B”.

The mission of the AGS, a nationwide not-for-profit organization comprised of nearly 6,000 geriatrics clinicians 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 clinicians paid under the Physician Fee Schedule 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 the committee’s willingness to listen to our concerns and experience with these programs. Our members and their patients are uniquely affected by Medicare, with a limited ability to cost-shift across payers.

MACRA replaced the unworkable cost control mechanism of the Sustainable Growth Rate (SGR) with a new payment system intended to incentivize value-based care. However, MACRA—particularly the provisions establishing the Merit-Based Incentive Payment System (MIPS)—uses an “accountability” mechanism that is largely siloed by individual disease states and conditions, focuses disproportionately on performance and payment at the individual clinician and individual specialty level, and, as a result of its budget neutrality requirements, picks clinician “winners” and “losers.” We cannot achieve the promise of value-based care with this fragmented approach, which is organized around organ-specific care and does not take a whole person approach to health and well-being. In our view, 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 and most importantly sustain 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 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 patient goals and experiences, person-oriented outcomes, and the total cost of care for that patient rather than on condition-or specialty-specific outcomes as a metric for higher reimbursement.
- Processes that facilitate relationships between the clinician team and the patient/family so that what matters most to the patient is always at the forefront of the care plan.
- 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 marginalized communities 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 reduces the 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 based on shared decision-making with their patients.
- Permanent access to telehealth services, which has become an essential standard of care.
- 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).

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.

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_vZfimFdXlvGg%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.

- 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.
- Payments that include:
 - Incentives that are generally positive, with 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 Medicare Economic Index (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 the future of physician payment. 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. Without a vibrant primary care delivery system there will be no attainment of value. Congress should not preoccupy itself with short-term savings to the detriment of long-term goals. As with any system 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 the Committee 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.**

We have also reviewed the questions outlined in your white paper and provided feedback below.

Addressing Concerns regarding Budget Neutrality in the PFS

1. **What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting processes?**

It is difficult to accurately predict utilization, especially of new, potentially widely used services. It is most appropriate to adjust to unexpected variance from predictions in subsequent rate setting, even though there will be a year delay for claims run-out and to analyze the data. If a threshold is set, it should not be by a single service code or family of codes, but in the aggregate. It would be acceptable that it be bidirectional (i.e. over/under). If the aggregated assumption was substantially underestimated, the correction should be phased in if it affects the conversion factor by greater than 0.5%.

Wide divergence at the code or code family level should result in referral to the RBRVS Update Committee (RUC) to consider whether review of recommendations is required. Additionally, CMS could evaluate utilization assumptions after a set period of time (e.g. 3 years), develop an updated utilization projection, and use that to mitigate errors in the original estimate.

2. **Should the Committee consider additional parameters to align the statute's budget-neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?**

The most important factor is to not implement budget neutrality unless it exceeds a threshold which is MEI (or other inflation factor) adjusted. Regulatory policy changes that negatively impact the conversion factor significantly (greater than 0.5%) should be phased in.

Incentivizing Participation in Alternative Payment Models

1. **In considering a new design for future A-APM bonus payments, are there existing demonstrations that structure A-APM incentive payments to reward providers that attribute beneficiaries to the A-APM?**

MSSP and Primary Care First are A-APMs that are existing demonstrations that are generally well designed to reward beneficiaries, even if both need improvements. They use attribution methodologies. Participation in an A-APM should result in a favorable conversion factor adjustment for all beneficiaries of the practice, not just those attributed and not for specific services only. There should be a meaningful level of participation in the A-APM, but it should be fairly low, for example if 25% of a specialty physician's services were to A-APM attributed beneficiaries, the practitioner should be eligible. If the specialist directly participates in downside risk for their services (and not as part of an ACO only), there does not need to be a beneficiary percentage threshold.

2. **What methodology should form the basis for incentive bonuses, if not total PFS revenue for all providers participating within an A-APM? What bonus structure best encourages new providers participating in A-APMs?**

We believe that the greatest value of an ACO is to align incentives of diverse providers. We believe the greatest value of Primary Care A-APMs is to support the transformation of primary care to advanced comprehensive primary care.

Total cost of care is very reasonable for MSSP. It is inappropriate for a program that does not have that focus such as Primary Care First (PCF). Primary Care First has reasonable incentives, though PCF pushes the limit of credibility when using hospital admission rates for smaller practices. Quality incentives are appropriate but must not be excessively administratively burdensome. Additionally, there needs to be fairness and eQMs may not be ideal as they are whole population and not just for the Medicare beneficiaries. If MSSP savings are realistically

attainable, this is an incentive. Downside risk requires a partnership with a larger entity as 5% total cost loss is roughly 100% of Primary Care payments. The FLEX ACO model allows pre-funding investments, which removes a barrier to ACO entry. Converting current payment levels to monthly payments per beneficiary for primary care services is a minimal incentive and the administrative burden would likely outweigh it. Enhanced payments are a meaningful incentive and would improve quality by funding nurse care managers, pharmacists, integrated behavioral health and social work. CPC+ and PCF are good models and should be made available voluntarily as an A-APM to all primary care practices. PCF needs some corrections on the Payment Accuracy Adjustment (“Leakage”).

Specialty specific A-APMs are too complex to administer, and savings would be outweighed by administrative costs in most cases. Additionally, they make Total Cost savings more difficult to achieve, unless the specialty share is not a cost to the ACO and not taken from the ACO savings. To have specialists participate, it would help to have the primary care base of an MSSP determine which specialists can be designated as participants. This would incentivize them to work with the PCPs. Once designated they would be eligible to receive an A-APM bonus annual adjusted increase. Therefore, the A-APM annual bonus must be significant enough that with compounding it is truly relevant to the specialist. The MSSP should be allowed to require the specialist to support investments and the specialist could recover the investment if there are shared savings. While a specialist withhold would be desirable to incentivize the specialist participating in the success of Total Cost, it would be very difficult to recruit a specialist unless the withhold was the lesser of other negative alternatives. The challenge of engaging the specialist in Total Cost savings is major. Other considerations may include allowing Principal Care Management or another Co-Management services to be paid only to MSSP participant specialists. It may also be necessary to consider specialty variation. For example, Endocrinology is almost all E/M and similar to Primary Care with respect to financial challenges and the need to provide many services that are not reported. It rarely generates high-cost services. That and similar specialties should be given special consideration.

3. Should the bonus continue to require participation thresholds, or modify or eliminate thresholds to allow for greater participation? How?

There should be a low threshold for specialists. In primary care, participation generally results in nearly 100 percent enrollment of the primary care population in the A-APM with only the complexity of attribution creating a result less than 100%. More significantly specialty A-APM eligibility should be determined by referring practices. The threshold should prevent specialists who must provide access to beneficiaries from any ACO from using endorsement by one small population ACO to enable the bonus. The threshold should have some relationship to the aggregate ACO penetration in the area. For example, if the area has 80 percent of the beneficiaries in an ACO of some type, then the specialist should have a 25 percent threshold. It might be reasonably lower if the penetration was only 25 percent. However, it should remain high enough to encourage specialists to push ACO formation so that they may benefit.

4. **Are there other A-APM programmatic designs that would make participation more attractive for providers?**

For Primary Care First the correction of the Payment Accuracy Adjustment is required. Continue and enhance quality reporting simplification in all programs. Do not require reporting methods that create high costs in aggregating and deduplicating the results. The planned MSSP reporting methodology will result in costs in excess of one million even for a small ACO to accomplish data aggregation, unless all participants use a single EMR. In some cases, it will wipe out any savings and stifle investment in personnel that could actually improve care. As some CMMI programs are regionally limited or numerically limited, removal of these limitations would stimulate participation. Most programs do require Risk Adjustment, but continued efforts to reduce gaming of the system and reporting burden by practitioners should be sought. For Primary Care the risk adjustment for monthly per beneficiary payments should not rely only on Total Cost of Care adjustment (HCC) but should include factors that adjust for the cost of providing Primary Care (e.g. PCALs in Massachusetts Medicaid).⁴ MSSP quality reporting should be simplified.

The A-APM bonus must be sustained and be meaningful. The flaws of MIPS/MVPs provide an incentive to participate in an A-APM, but we cannot endorse retaining MIPS/MVPS for the sole purpose to incentive departure from those programs.

If some benefits were created within Medicare Advantage based on a practice's participation in a Medicare A-APM, that would create an incentive. Most notably a required reduction in Prior Authorization (PA) burden based on Traditional Medicare A-APM participation would be a stimulus.

Some MSSPs discourage specialist participation based on their past experience of the specialty attributed patients as predictably exceeding the budget. For example, the cost of cancer care has increased at a rate far greater than any budget increase. An MSSP inevitably will need to keep oncologists out of their ACO in order to succeed. This is antithetical to care coordination and whole person care.

Generally speaking, the current risk-reward calculus is not always favorable for provider participation. This is especially true for already high performing groups or those with a lower baseline cost, because of the use of historical cost data to set targets.

⁴ Ash AS, Ellis RP. Risk-adjusted payment and performance assessment for primary care. *Med Care*. 2012;50(8):643-653. doi:10.1097/MLR.0b013e3182549c74

5. **How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?**

As noted above, we do not believe it is feasible to focus on specialty A-APMs in general. Specialists should be incentivized to contribute to whole patient care.

ACOs led by primary care or independent groups need an opportunity to receive upfront investment (e.g. FLEX ACO). Downside risk on Total Cost of Care must be minimal. Upside risk must have real possibility of success to support investment and should not drop below a result that approaches \$15 per beneficiary month. As CMS must use its share of savings to blunt its share of loss, other measures than downside risk that is potentially bankrupting for the practice or groups should be designed (e.g. temporary removal from a program with a remediation plan for re-entry). CMS should create a support branch that can help create a remediation plan with such groups and then continue to support implementation.

6. **What programmatic flexibilities, with respect to A-APMs or smaller models or pilots, would help to ensure a broader and more diverse array of options for clinicians?**

A diverse array is not necessarily helpful. It creates fragmentation and complexity. Please refer to answers above.

7. **Are there other A-APM programmatic designs that would make A-APMs more attractive to beneficiaries to increase attribution and thus support A-APMs?**

The goals should be to make A-APMs successful in transforming to more effective and patient-centered, patient-supportive organizations. This will likely lead more beneficiaries to seek care from such participants. Dislocation of patients within a community delivery system that already has substantial deficiencies in workforce by use of incentives that encourage abrupt movement is not a positive step. Most practices already want to improve and be high quality. The missteps created by Medicare Advantage plans with changing narrow networks should not be repeated.

If CMS were to extend some incentives so that Medicare Advantage had to accept them for qualified practices, that could be an incentive, even for beneficiaries. Most notably this would include requiring substantial reduction and improvement in the prior authorization process. The current prior authorization process not only adversely affects practices, but also adversely affects beneficiaries.

Reducing Physician Reporting Burden Related to MIPS

1. **What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?**

MIPS is a failed program that creates an additional burden that takes away from investing in resources that support clinicians in providing quality care (e.g. team care, care management). The costs and burden associated with the program vastly outweigh the benefits (if there are any). We believe that MIPS should be phased out.

In order to incentive quality improvement that matters a core set of population metrics should be used, not something for every specialty or practitioner class (e.g. physicians, therapists). Eligibility for incentive programs is useful in Primary Care. This is the design in CPC+ and PCF. Specialists could be incentivized based on measures that typically are considered primary care. They would therefore have a role in supporting important population measures. No practitioner has control over quality results. While specialists may view the population measure as outside of their control, it may promote a mindset of having a role as part of the population care team and not as a single disease or organ class practitioner. Measuring quality at the practitioner level is folly. Expecting every specialty to have a valid set of metrics is also unrealistic and wasteful.

Good patient satisfaction information can be useful for improvement and measurement. However, current survey methodology is expensive and may not be worth the investment. The most effective way to encourage improvement is to determine what transformation in delivery is needed and then to support it. For example, it is clear primary care needs to have a team to meet the diverse needs of patients and to sustain a workforce as fewer physicians enter the field. Therefore, programs like PCF that fund team-based care improve quality by causing structural change.

2. **Are there existing practice improvement activities or incentives, such as data registry participation, that should continue as a means of promoting individual clinician quality of care?**

No. Individual clinician quality is not relevant. An internal registry so that the practice knows which patients need greater attention is necessary at the practice level without reporting. Accordingly, EMR developers must be required to support this and properly configure quality measures in a manner that minimizes practitioner burden. Many EMR developers fall woefully short in this regard. This failure along with excessive prior authorization requirements are probably the two greatest causes of abrasion in physician practice and the aversion to entering or remaining in primary care. The abrasion not only leads to frustration, but disrupts patient care.

Supporting Chronic Care in the Primary Care Setting

1. **In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?**

We believe that a hybrid model for primary care services is very desirable. PCF provides a good model but can be improved. It appropriately addresses payment for office visits, care management and advance care planning. It appropriately does not include hospital or nursing home services. However, it should not include home/residence visits unless those beneficiaries have a special payment rate. There is no incentive to see a patient who usually comes to the office in the home. Most importantly, it is not just an actuarial summary of what would have been paid piecemeal, but it includes additional support for a broad array of services that have no billing codes. It supports building a team both because of the funding and because population payments incentivize caring for the population efficiently.

There are major problems in the PCF Payment Accuracy Adjustment that must be fixed, most notably penalties when a beneficiary sees an advance practice nurse that is in a specialty practice. Other concerns include counting advance care planning, geriatrics and palliative care as a service that the PCP “should have performed” and thus are subject to penalty. The PCP may have performed advance care planning, but another clinician appropriately does so as well. Why is there a disincentive to refer to geriatrics or palliative care, but no disincentive to refer to orthopedics or cardiology? This is inconsistent with good patient-goal centered care.

The flat visit fee should reflect the fixed cost of a visit so there is no disincentive to see the patient.

A similar program could be designed for homebased care of patients who routinely require home-based E/M care by the primary care team. It also could be designed for a subset of patients who are unusual, and PCF does have tiers for a highly complex subset, but complexity adjustments should reflect the cost of the primary care services, not the total cost of care.

The program could bundle in low value services that may be commonly overused such as “routine” EKGs. There should be consideration given to allowing some extra payment for Annual Wellness visits (AWV), which are underused. The PCF flat visit fee is for any number of E/M or E/M like services performed on the day. Cost sharing remains the beneficiary responsibility, but since there is no cost sharing for AWV, there is no incentive for the practitioner. Vaccine administration is not bundled into the monthly payment, and this is appropriate to incentivize this important activity.

We believe specialty models are challenging, though it may be possible to design such programs. End stage kidney disease management services are paid in a hybrid manner. CMMI is just beginning the [GUIDE program](#) to support dementia care. This is a promising model and there may be similar models for palliative care support to primary care practitioners and their patients.

2. **Should a hybrid model design include a hybrid-specific risk adjustor for primary care?**

We believe this is essential. Equally important is that any quality bonus/penalties are valid for a higher risk population. For example, PCF uses Acute Hospital Utilization (NCQA®), but the validity on a small population that is not in the middle of the bell curve of complexity is questionable. It is essential that whenever such adjustments have a meaningful impact in payment (e.g. above 5%) that they be valid for the practice that is measured and not simply valid across a large “typical” population.

We believe there needs to be investment in risk adjustment methodology. It may be that the current total cost of care adjustor (HCC) influences the cost of primary care but other factors such as activity of daily living capacity and social deprivation may be highly relevant. The latter can be derived by zip code and does not create a measurement burden.

We acknowledge the potential gaming around HCC coding and the administrative burden placed on clinicians to know coding and use ICD 10 codes in a manner that allows accurate reflection of risk. Some day there may be simpler methodology, less subject to diverting resources from care to coding. Perhaps standardized AI analytics of notes may help. Research and development of the risk adjustment factors and data acquisition is needed and worthwhile given the major impacts on payments in primary care and for primary care clinicians who must succeed in MSSP to remain financially viable.

3. **How can such a policy account for quality?**

A concern may be that without an incentive to provide higher quality there could be stinting of services or poor quality. This is the legacy of some bad actors in “managed care” in the late 1980s. However, do not forget that there were outstanding HMOs like Harvard and Kaiser. First, one must decide what is quality and then determine if it can be measured without undue burden and cost. For general primary care, measures like blood pressure and diabetes control are appropriate and they lead to processes being put in place that improve results. Measures of patient satisfaction with care matching values (i.e. a measure of implementation of what matters most) are highly desirable for the complex multi-morbid beneficiary. But surveys may be too costly to measure, so recognition as an Age-Friendly Practice may be more pragmatic. The PCF Payment Accuracy Adjustment is a good example of an erroneously constructed measure based upon reasonable concerns of stinting. Outlier analysis and action would be more reasonable.

A general problem in quality measurement in many areas is that it does not assess diagnostic accuracy, medical decision making nor differences in care. For example, the patient who never has their diabetes diagnosed never gets in the diabetes control measure. Perhaps the best example is measuring the quality of a surgical procedure such as an elective total joint replacement. The appropriateness of the surgery is not assessed and those who appropriately had no surgery do not get into the measure. The complication rates are so low that they are more likely to be random than reflect quality differences.

Overall, quality outcomes are still disease-based for many primary care models with insufficient stock of measures that account for whole-person care, quality of life, and individual patient preferences.

4. **Are there benefit design flexibilities that would ease financial burden for ACO attributed beneficiaries who require chronic care management?**

There could be financial incentives for care management services, particularly to historically minoritized and rural communities (e.g., support for self-care or navigating complex health systems). Telemedicine for beneficiaries in their home must be permanently sustained.

5. **If Congress were to pursue such a hybrid model design, should policymakers also differentiate the CF, budget-neutrality adjustments, and other mechanisms to promote team-based care and appropriately account for distinctions in payment models across specialties and subspecialties?**

Payment must be adequate to achieve goals of team-based care. Having an additional CF incentive is nice. CPC+ and PCF were A-APMS so it was a double win in receiving supplemental infrastructure support and an enhanced conversion factor.

A way to promote team-based specialty care could be an eligibility factor that allows a higher CF (see A-APM comments above) which could include recognition in a Age Friendly Health System (AFHS).

The additional payments cannot be budget neutral. That will pit specialties against hybrid payments for primary care. G2211 is a good example of an appropriate payment policy that created conflict. If it did not have budget neutrality, there would have been no conflict. The Primary Care Incentive Payment of the Affordable Care Act did not create conflict.

6. **If so, how should Congress structure such differentiation?**

See above.

Supporting Chronic Care Benefits in FFS

1. **Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?**

Longitudinal care by an appropriately constituted and financially supported interdisciplinary primary care team.

2. What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?

Medicare beneficiaries need permanent access to telehealth. We have learned telehealth can improve safety and access for Medicare beneficiaries when they receive healthcare services. We also have experienced the need to cover audio only services due to issues with patients' technology management challenges and broadband access. These services can effectively substitute for in person visits and create access for those that previously lacked the ability to get medical and behavioral healthcare needs met. However, insufficient payment for these services undermines a practice's ability to provide telehealth services.

Additionally, evidence-based programs that aim to improve chronic care for older adults should be better utilized. For example, CAPABLE is a person-directed, home-based program that addresses both function and healthcare expenses. The program is being recognized by Federal and State agencies as an effective program in improving health and decreasing costs among older adults. The four to five-month program integrates services from an occupational therapist (OT), a registered nurse (RN), and a handy worker who work together with the older adult to set goals and direct action plans that change behaviors to improve health, independence and safety.

Ensuring the Integrity of the PFS

1. What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS's RVU and rate-setting processes?

Integrity usually refers to fraud prevention or detection. The CPT Editorial Panel makes efforts to support accurate coding when creating descriptors and guidelines. Correct coding initiative edits (CCI) are supported and reviewed. The CPT Guidelines are not considered the legal standard, only the descriptors and this interpretation of the HIPAA standard has facilitated some in skirting proper coding.

AGS believes the greater concern is the accuracy of the current valuations. The process at which they are reached has been created by statute and rulemaking. We believe it is essential that the profession remains very involved in a manner that physician and nonphysician professionals are represented. The current RUC structure allows for that. It is also the only entity likely to do the detailed work and critical assessment of an expert panel. If CMS or others facilitated data collection it may have additional information to use. Currently CMS datafiles about types of patients (in Medicare), condition, site of service and specialty are used. When some anomalies are noted the CMS public database by code has been used to detect misuse. These have been reported, but it is unknown what, if any, action has occurred. Medicaid data would be extremely useful for those services that are not typically for Medicare beneficiaries. Other reliable data sources would be useful, but presently are unavailable or too costly to acquire.

The indirect practice expense allocations, specialty pools and scaling factors need review and probable revision. Currently an inpatient surgical add-on code (e.g. an additional service during spine surgery) creates indirect practice expense in the valuation by CMS even though it is hard to understand how any additional indirect expense is incurred. Likewise, high-cost supplies create indirect inputs that are illogical.

AGS supports current levels of coding granularity, in general. A payment by groups used by the Hospital Outpatient payment methodology would probably not serve physicians well, because professionals do not perform the breadth of services that a hospital does.

An advisory body on methodologies may be useful. It is unclear what authority that body would have as MedPAC already makes recommendations that are not accepted by CMS. The advisory body should make methodological, not valuation recommendations. It could also suggest screens for the RUC to use in identifying potentially misvalued services. Some individuals or groups already engage in recommendations during the rulemaking process and in the Medicare Physician Fee Schedule 2024 rulemaking CMS solicited general input on this topic. While this potential body must have physician members, it may be another body with a broader view, more able to suggest policy as compared to values and inputs, than the RUC. It may create a greater degree of comfort with the objectivity of the valuation process, whether or not current criticisms are justified.

CMS currently allows anyone to nominate codes as potentially misvalued, though CMS does not always ask the RUC to review them.

2. For more than 25 years, a Refinement Panel provided a relative value appeals process for CMS's annual PFS processes. Should the agency consider reinstating such a panel, and if so, what modifications, if any, would help to ensure independence, objectivity, and rigor?

We believe refinement panels should be reinstated. During the 3rd 5 Year review, E/M codes were re-valued and RVU increases were recommended and accepted. The RBRVS method required that some E/M services needed to be used for reference, so they could not be revalued. The Home visit codes were used. This means that they were not increased in value and due to budget neutrality, they decreased in payment levels. The use of a refinement panel substantially corrected this situation. CMS could create specific criteria for refinement justification, but this process probably needs to be flexible as it may be used in atypical instances, for example, the home visit codes. CMS can create a methodology of review that is standardized, rigorous, yet flexible. Ultimately, CMS accepts or rejects the recommendations.

3. What third-party entities could produce the most credible and reliable analysis of CMS's RVU determination and rate-setting processes, and what key areas should such analysis examine?

There is no clear entity candidate. Contractors and research organizations, such as RAND have done some limited work. There are some individuals with considerable expertise in this area.

This may justify an advisory body as compared to an existing entity. Whatever process is used, it should include opportunity for input and comment before issuing any “final” report, even if reports are ongoing (e.g. annually). If CMS proposes to accept recommendations, then those recommendations should go through rulemaking. Most current activities and policies have a basis, therefore changes must be weighed in terms of pros and cons. An example is the global periods. They were created to reduce “churn” and unnecessary follow-up visits. They are a small version of prospective payments. The values include probable visits. This then raises justifiable concerns that the values are inaccurate if the visits do not occur. Should efficiency result in reduced payment? While it probably should, some percentage of services would have a follow-up visit reported if the global was removed. Would that increase or decrease expenditures? These are detailed and nuanced considerations.

Areas that could be assessed include:

- Indirect practice expense methodology
- Global periods and suggested RVU adjustment methodologies if post service visits are not typically performed
- Data availability and acquisition feasibility for supporting the valuation processes (presently surveys).
- Additional screens for potentially mis-valued services.
- High-cost supplies
- Intra-service work per unit of time and work per unit of time patterns

AGS believes the major issues are not these detailed matters, even though they are important. CMS and the RUC follow statute and use methods defined by rulemaking. The major issues are policy matters that probably require statute, especially in light of recent decisions to limit deference to the administrative branch. We applaud CMS for deciding certain activities were within its authority such as creating additional payment for primary and complex continuous care by creating G2211. We applaud the creation of coding for services to address Social Determinants of Health and Principal Care Navigation and the valuable services of community health workers, navigators and peer support specialists. Decisions such as not using the new increased E/M values in the surgical global periods may have been good policy for some surgical services, and supportive of “cognitive” specialties, but we already face a shortage of general surgeons, who may have been adversely affected. Valuing a typical service does not address the challenges of a rural practice. The RBRVS system is about resource inputs and relative valuations, not value to society. It is a methodology that is most consistent with a fee for service system. We believe Congress should address methods to foster and support primary care, rural care and care for the disadvantaged. Refining the RBRVS system will not address the challenges of access and health care disparities that reduce our national productivity and are the source of tragic morbidity, functional impairment and mortality.

We sincerely appreciate the Senate Finance Committee’s leadership and commitment to reforming MACRA to stabilize physician practices and strengthen primary care, particularly for older adults living with chronic conditions and/or functional limitations. The AGS believes that traditional Medicare must remain a strong, viable option to help balance market forces in Medicare Advantage and preserve beneficiary choice and access. It is crucial that reforms to the payment system ensure that we have a robust primary care workforce that is equipped and able to deliver the person-centered care that Medicare beneficiaries deserve; that is, assuring the primacy of individuals’ health and life goals in their care planning and in the care they receive. The AGS looks forward to working collaboratively with the committee to achieve these goals as you develop legislative solutions. Should you have any questions and would like to speak further about our recommendations, we would be pleased to do so. Please contact Alanna Goldstein, at agoldstein@americangeriatrics.org.