

July 15, 2024

Senator Sheldon Whitehouse  
Senator Bill Cassidy, MD  
United States Senate  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

**RE: Cassidy, Whitehouse Request for Information on Primary Care Provider Payment Reform**

Dear Senators Cassidy and Whitehouse:

The American Geriatrics Society (AGS) appreciates the opportunity to provide feedback as you look to accelerate efforts to support value-based primary care and improve payment for primary care providers in Medicare. We applaud your ongoing work in this area and your recognition of the critical role that primary care, with its whole person approach to health, plays in the larger health care system. Robust primary care can provide better health outcomes, improved health equity, and reduced health spending. We urge you to advance legislation that would establish a voluntary hybrid payment model for primary care that includes both a capitated payment for care coordination activities and appropriate separate payment for evaluation and management (E/M) visits. In addition, we strongly recommend that the legislation permanently reinstate the primary care bonus<sup>1</sup> to provide additional support to primary care providers, including geriatrics professionals.

AGS is a nationwide not-for-profit organization dedicated to improving the health, independence, and quality of life of older people. Our 6000+ members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician associates, pharmacists, and internists who 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 care partners. AGS is actively engaged in efforts to advance value-based, high-quality care for all of us as we age. Our members focus almost exclusively on caring for Medicare beneficiaries and therefore have unique insight to share about the needs of this population and the challenges posed by the current payment environment.

AGS believes that a high-quality, cost-effective healthcare system results from care that is person-centered, team-based 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*

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<sup>1</sup> See Section 5501 (a) of the Affordable Care Act, Public Law No: 111-148.

*Primary Care*<sup>2</sup>, the payment system must value primary care and be focused on the health and well-being of the whole person across settings of care. We appreciate the focused attention that Senators Cassidy and Whitehouse are placing on system transformation, ensuring that Medicare beneficiaries have access to primary care clinicians, and the intentional focus on payment as a powerful policy lever for supporting primary care clinicians. The current disparity in earnings between primary care and specialists is a major contributor to the workforce shortages of primary care practitioners and has created a crisis situation for primary care practices. Primary care is not furnished by individual practitioners but by multi-disciplinary teams that can respond appropriately and efficiently to patient needs.

If we are to attract the workforce that is necessary to support the transformation of primary care, Congress should take immediate action to boost payment for primary care clinicians and ensure that the infrastructure is there to support person-centered, goal driven healthcare. At this juncture, our fee-for-service payment system is misaligned and does not adequately support the multi-professional care team that provides longitudinal, well-coordinated care, manages the complexity of multiple chronic conditions, and pays attention to frailty. This is particularly true for many Medicare beneficiaries. Nearly 45 percent of Medicare beneficiaries have four or more chronic conditions<sup>3</sup> and account for more than 75 percent of Medicare expenditures.<sup>4</sup> Absent an across the board increase in payment for primary care, the hybrid payment model proposed in the Pay PCPs Act is unlikely to achieve the stated legislative goal of improving health outcomes, increasing equitable access to care, and reducing overall health spending. We urge Congress to restore and make permanent the Medicare 10 percent primary care bonus payment that was part of the Affordable Care Act (this payment expired at the end of 2015). A permanent increase would help create a more stable environment and provide an incentive for new physicians, advanced practice nurses, and physician assistants to enter and stay in primary care, including geriatrics.

Congress must also exclude the permanent primary care bonus from the budget neutrality requirements of the Medicare Physician Fee Schedule (MPFS). To do otherwise would mean that investment in primary care would result in reductions in payment for other clinical services and may inadvertently hurt some primary care providers. For example, if new resources are only available for office-based primary care and budget neutrality is applied, geriatrics health professionals and other primary care clinicians who provide home-based or nursing facility care will see cuts in payment. This occurred with the implementation of the visit complexity add-on code within Medicare, G2211, for 2024.

Below we describe what AGS believes is necessary for attaining true value-based care and answer the questions outlined in your Request for Information.

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<sup>2</sup> 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).

<sup>3</sup> Centers for Medicare and Medicaid Services. Medicare Current Beneficiary Survey 2018 Chartbook. Published December 8, 2020. Accessed May 1, 2024. <https://www.cms.gov/files/zip/2018-medicare-current-beneficiary-survey-annual-chartbook-and-slides.zip>

<sup>4</sup> Aspen Health Strategy Group. Reducing the Burden of Chronic Disease: A Report of the Aspen Health Strategy Group. Published 2019. Accessed May 1, 2024. <https://www.aspeninstitute.org/wp-content/uploads/2019/02/AHSG-Chronic-DiseaseReport-2019.pdf>

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

- A whole-person orientation 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 report of the National Academies of Science, Engineering and Medicine: “Implementing High Quality Primary Care,”<sup>5</sup> 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.
- An intentional commitment to equitable care and reducing disparities by, among other strategies, financially supporting organizations embedded in underserved communities.

Congress should 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. 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. Quality measurement requires significant administrative resources and should be undertaken only for measures proven to impact patient care and 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.

AGS believes that a hybrid payment model that includes a capitated element for care coordination, appropriate separate payment for evaluation and management (E/M) services, and a bonus payment specific to primary care will support the transition to truly value-based care.

#### **Hybrid payments for primary care providers (PCPs):**

- **How can Congress ensure we are correctly identifying the primary care provider for each beneficiary and excluding providers who are not a beneficiary's correct primary care provider or usual source of care?**

Primary care is not based on the volume of services received from a certain practitioner but is determined by the type of care provided. The National Academies’ 2021 report defined high quality primary care as: “High-quality primary care is 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.”<sup>6</sup> PCPs are practitioners who furnish such comprehensive, longitudinal care. While some beneficiaries may see certain specialists regularly and perhaps even more frequently than their PCP, those specialists should not be considered PCPs if they treat patients only for certain conditions or in acute situations.

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<sup>5</sup> National Academies Report.

<sup>6</sup>National Academies Report, p. 4.

To identify PCPs, Congress could use a methodology that looks at billing patterns for services that would likely only be furnished by PCPs such as the Annual Wellness Visit (AWV). For example, practitioners for whom claims for the AWV are a specified minimum percentage of the total services furnished could be identified as PCPs and eligible to receive the hybrid and supplemental PCP payments. Congress could also require practitioners identified through Medicare claims analysis to attest that the care they furnish has the necessary attributes of primary care before receiving PCP payments. This approach is consistent with current Medicare demonstration models such as Primary Care First which require an application from the practitioner to be classified as a PCP and participate in the model.

In addition, Congress should require that beneficiaries confirm that a practitioner who meets the definition of a PCP is an individual beneficiary's source of primary care. The process of obtaining beneficiary confirmation also provides an opportunity for Medicare to communicate with the beneficiary about the role and advantages of seeing a PCP.

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. A multi-step attribution process that explicitly and prospectively identifies patients receiving primary care from a specific practice will best avoid these issues.

Congress and CMS should address the practitioner nomenclature and enrollment processes for Advanced Practice Nurses (APRN) and Physician Associates (PA). Presently CMS cannot distinguish APRN or PA practitioners who are in primary care practices compared to specialty care. Classifications need to reflect practice, not education or even state licensure categories for these practitioners that may furnish different types of care.

- **How should Congress think about beneficiaries who regularly switch primary care providers? What strategies should CMS use to minimize disruption and administrative burden for these providers?**

We question whether there is evidence that this situation occurs other than rarely under fee-for-service Medicare. We believe the drivers of multiple PCPs is more an issue of providers leaving the workforce or changing employment. Rather than focusing on patient switching between PCPs, Congress should address situations in which a PCP may change because of common shifts in medical practice, such as the impact of new, retiring, or relocating practitioners. In most instances, groups/practices will continue to manage the same patient population and furnish primary care to those patients even if one practitioner comes or goes and therefore it is reasonable to consider the primary care practice as the PCP. We support attributing a beneficiary to a practice rather than an individual PCP.

- **How should the legislation address beneficiaries who routinely see two or more providers who could each plausibly be the "primary" care provider? For instance, a beneficiary who routinely visits both a family medicine provider and an OBGYN.**

The legislation should focus on “primary care” which is comprehensive, longitudinal care, not on “primary” care which might imply visit volume. Only one practitioner/practice is the PCP and only those correctly classified as PCPs are plausibly the “primary care” provider. An OBGYN does not furnish primary care, because most OBGYNs will not address a chronic illness unless it is gynecologically related. Medicare Advantage and Medicaid have addressed this issue. While both usually require PCP selection, they also have rules regarding who can be a PCP. As suggested above, Congress could use volume of services that are uniquely primary care services, such as the AWWV, as means of identifying PCPs and then confirm with both the practitioner and the beneficiary that they are in fact the beneficiary’s PCP. Specialists that do not provide primary care should not receive capitated amounts or supplemental payments.

- **What methodology should be used to determine the "actuarially equivalent" FFS amount for the purpose of the hybrid payment?**
  - **Should hybrid payment rates be based on historic averages across the entire FFS population? If so, are there risks that providers will receive an inappropriate payment rate for certain unusually high- or low- utilizing beneficiaries?**

We are pleased that the Pay PCPs Act contemplates a risk adjustment methodology that reflects the practice expenses for furnishing 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.

One option is to look at whether hierarchical condition category (HCC) risk adjustment factor (RAF) scores relate to the number of primary care visits and primary care non-visit activities per year. Researchers have published on this,<sup>7</sup> but HCC adjustments are more commonly associated with prediction of total costs, not specifically primary care costs. 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.

In defining the practice costs of providing comprehensive primary care, it is critical to look at how care management is affected. For example, dementia may not be as big a factor in total cost of care as it is for the cost of primary care management. Diagnosis-based risk adjustment may be insufficient to properly capture the relevant factors. It may be necessary to include other elements such as functional characteristics. Primary care may best be furnished in the home for some patients and home services are more costly to provide than an office visit.

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<sup>7</sup> 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

Currently, the Medicare Physician Fee Schedule payment for a moderate complexity established patient office visit is the same as a moderate complexity established patient home visit and the home visit is not eligible for the visit complexity add-on payment despite the fact that the two services are not equivalent. Use of home visit codes should result in higher capitation or a higher visit fee if a visit fee is part of the hybrid method.

Any RAF system will create the potential for gaming and the administrative requirements to avoid gaming can distract from clinical care. The RAF should be as automatic as possible: age, gender, ADI by zip code, site of service, and a limited number of diagnoses. Excessive focus on ICD-10 coding, as can occur for Medicare Advantage patients, shifts attention from care provided during the encounter and from care management.

- **What factors should Congress be considering when setting risk adjustment criteria?**
  - **Should beneficiaries on Medicare Advantage be considered as part of the calculation or should Congress limit the pool to FFS only?**

Congress should consult with RAF experts on this issue. It seems useful to consider the largest number of beneficiaries. However, HCC coding efforts are far greater in MA and therefore inclusion of that population may distort the FFS payment calculation. In addition, MA plans may already pay based on population factors. Calculations should be run on both the populations separately before considering analyses on the combined population.

In addition, as noted above, experts should opine on the appropriateness of using HCC for primary care as well as the incentives to “upcode” created by the HCC.

- **The legislation proposes to allow the Secretary to define quality measures for hybrid payments and suggests four which may be pursued: (1) patient experience, (2) clinical quality measures, (3) service utilization, including measures of rates of emergency department visits and hospitalizations, and (4) efficiency in referrals, which may include measures of the comprehensiveness of services that the primary care provider furnishes.**
  - **Are these quality measures appropriate?**

Possibly but all have limitations. Patient experience is valuable, but data acquisition is costly. If the burden of obtaining data is placed on the practice it would negate the positive goals of this proposed program. Clinical quality measures are typically disease specific and should be limited to those that are appropriate for primary care based on the relevance of certain conditions, such as blood pressure or diabetes control.

Service utilization measures are particularly complicated. Hospitalization rates need to be calculated on a substantial number of hospitalized patients to be valid (e.g., because a physician who hospitalizes one patient that is a cost outlier can skew the data dramatically), and usually are calculated as observed/expected based on complex risk adjustment algorithms using years of past claims. ED use may reflect access, but it may also reflect disease burden. Algorithms such as the NYU (Billings) system have questionable validity in measuring

practitioner/practice level quality. We are not aware of an efficiency of referral measure that is in common use. One might consider a ratio of specialist visits to primary care visits which may identify outliers but be otherwise insensitive to measuring quality. Referrals for palliative care or to a geriatrician should not be considered a specialist visit. Measures such as referral efficiency are novel and untested to implement on such a large scale.

Congress and CMS should avoid using unnecessary or unproven measures. Any new measure takes a significant amount of time for practices/providers to learn and 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.

- **Which additional measures should Congress be considering?**

A single structural measure such as recognition as an Age Friendly practice<sup>8</sup> may do more to positively transform care than numerous complicated measures. Hybrid and supplemental PCP 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.

Congress also needs to consider scaling of quality measures based on factors such as health related social needs (social determinants of health). In particular, service utilization measures should recognize the impact non-medical elements can have on achieving care goals. For example, access to transportation can affect a patient's ability to receive timely care and avoid costly exacerbations and diabetes control is affected by the cost of prescriptions and patient financial resources.

- **What strategies should Congress pursue to minimize reporting and administrative burden for primary care providers who participate in the hybrid model?**

There should be limited numbers of measures available for use and standard measures that clinicians are already using should be the basis for the measure set. The measures chosen should be easily collected in Electronic Medical Records (EMRs). We also urge caution when it comes to eQMs as it is unclear whether they are fair because they are whole population results. Comparison of results for two different Medicare populations may be appropriate, although that is not necessarily a given, but comparing patient

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<sup>8</sup> Institute for Healthcare Improvement. "Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults" (2020).

populations that have a high share of Medicaid or uncompensated care with populations that have little or no Medicaid or uncompensated care is not.

- **The legislation allows the Secretary to include four types of service in hybrid payments: (1) Care management services, (2) Communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) Behavioral health integration services, and (4) Office-based evaluation and management visits, regardless of modality, for new and established patients.**
  - o **Is this list of services appropriate?**
    - **Are there additional services which should be included?**
    - **Are there any services which should be excluded?**
  - o **Will including these services in a hybrid payment negatively impact patient access to service or quality of care?**

The most effective way to improve primary care is to properly pay for providers and practices to see beneficiaries. We are concerned that including office visits in the capitation will create disincentives to furnish needed 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. In addition, for many PCPs, including many geriatric 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. Rather than providing additional support for primary care, this approach would further financially disadvantage PCPs. If a portion of expected office visit expenditures is capitated to promote alternate visit types, there must still be an office visit fee that covers the practice expenses. This makes the decision to see the patient or not see the patient one that is clinical and not economic.

The capitated payment should support elements of primary care that are poorly recognized under the fee-for-service payment system or administratively burdensome to report. It also must support care teams. Primary care has costs associated with it that are currently not adequately compensated. For Calendar Year 2025, CMS is proposing to establish three new G codes for advanced primary care management services (APCM) that would incorporate elements of several existing care management and communication technology-based services into a bundle of services. The new codes are intended to reduce the administrative burden associated with current coding and billing for clinicians who participate in advanced primary care models.<sup>9</sup>

This lack of adequate support has resulted in few new graduates going into primary care and an insufficient number of primary care practitioners to serve Medicare beneficiaries despite a growing population. A major goal of any legislative effort should be to make primary care more attractive. A poorly designed hybrid payment model could have the opposite effect as these models are more conceptually complex than FFS and could lead to a greater sense of feeling disempowered in a practice type that already feels disempowered. A hybrid model that supports team-based care will also

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<sup>9</sup> Calendar Year 2025 Medicare Physician Fee Schedule Proposed Rule. CMS-1807-P.

help create the interprofessional education practice sites needed to train the next generation of PCPs and generate interest in primary care.

We support incentivizing increased communication to support coordination of care for patients and their caregivers. These services often involve complexity in tracking and billing that make fee-for-service payment difficult. We support team based-care including behavioral health integration. We support expanding and making permanent appropriate access to telehealth services to improve access to primary care.

The voluntary hybrid payment should include additional support for a broad array of services and staff that have no billing codes. 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.

#### **Cost-sharing adjustments for certain primary care services:**

- **What is the appropriate amount of cost-sharing to make the hybrid payment model attractive for beneficiaries and providers while constraining negative impacts on the federal budget?**

Beneficiaries should not be liable for cost-sharing for population-based payments. A supplemental payment to build the care team and a hybrid E/M (i.e. payment that is partially capitation and partially a visit fee) will provide appropriate population-based payment and better support development and maintenance of primary care practitioners. Failure to sustain primary care will have a substantial adverse effect on the Federal Budget. 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.<sup>10</sup> However, there is a current and looming shortage of primary care providers, including geriatrics. The Health Resources and Services Administration (HRSA) projects a national shortage of 68,020 primary care physicians by the year 2036.<sup>11</sup>

Congress may also want to consider other mechanisms to incentivize beneficiaries to maintain a strong relationship with a PCP. For example, Congress could reduce or eliminate beneficiary cost-sharing for E/M visits furnished by designated PCPs or apply a modest reduction in the Part B premium for beneficiaries who have designated a PCP.

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<sup>10</sup> 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>.

<sup>11</sup> [State of the Primary Care Workforce 2023 \(hrsa.gov\)](https://www.hrsa.gov/state-of-the-primary-care-workforce-2023).

- **Besides, or in addition to, cost-sharing reduction, what strategies should Congress consider to make the hybrid payment model attractive for beneficiaries and providers?**

Beneficiaries care about how any such model will affect their care. The biggest attraction to beneficiaries and our population at large is that there will be a strengthened primary care system.

#### **Technical advisory committee to help CMS more accurately determine Fee Schedule rates:**

- **Will the structure and makeup of the Advisory Committee meet the need outlined above?**
- **How else can CMS take a more active role in FFS payment rate setting?**

AGS agrees the physician fee schedule methodologies and processes can be better and supports the idea of a technical advisory committee to review and address the current methodology. Our understanding is that the advisory committee would not be a replacement for the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) or perform the type of service-specific assessment the RUC performs. Instead, the advisory committee could help assess bigger structural and methodological issues affecting physician payment.

Areas that could be assessed by the technical advisory committee include but should not be limited to:

- Indirect practice expense methodology.
- Global periods and suggested adjustment methodologies if post service visits are not typically performed.
- Data requirements, availability and acquisition feasibility for supporting an improved valuation process (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.
- Cost of complex patients, rather than valuations based only on the typical patient.
- Research and development on how to distinguish payment methods and payment models.
- Research and advise CMS on advantages and disadvantages of grouping procedures into payment groups to reduce the false precision of code-by-code valuation, while recognizing that code granularity may be needed for reasons other than payment. For example, by grouping procedures with similar intensities and then applying empirically derived times.
- Payment bundles, such as the population payment in the proposed legislation and how the Medicare program may allow new bundles.
- Development of a general exceptions process to address atypical intensity and outliers.
- Other methodological and research matters and the estimated funding or methods to develop an evidence basis for valuation decisions and payment models and methodologies.

Any technical advisory committee should be structured so as to include input from all segments of the medical community to avoid the perception that only the primary care subset of the profession will be involved in the physician fee schedule. If not, the entire hybrid model may be strongly opposed by many physicians. We would not want to see the failure of a major transformative goal because of opposition to this element.

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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.

The AGS thanks you for your leadership and commitment to reforming primary care and welcomes the opportunity to work collaboratively with you as you further develop legislative solutions. Should you have any questions and would like to speak further about our feedback, we would be pleased to do so. Please contact Alanna Goldstein, at [agoldstein@americangeriatrics.org](mailto:agoldstein@americangeriatrics.org).

Sincerely,



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