

Statement for the Record
Unites States Senate Committee on Finance Hearing
Bolstering Chronic Care through Medicare Physician Payment
April 11, 2024

American Geriatrics Society
40 Fulton Street, Suite 809
New York, NY 10038

The American Geriatrics Society (AGS) greatly appreciates the opportunity to provide feedback to the Senate Committee on Finance as it begins its efforts to develop legislation to reform the Physician Fee Schedule and update MACRA.

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.

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, 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 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.
- 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 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.
- 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.

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_yZfimFdXlvGg%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.

- 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. 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.**

Our recommendations for steps that Congress could take that stabilize the payment system include:

1. Foster performance-based care that values and supports geriatrics care teams for complex and high-cost patients.

The Center for Medicare and Medicaid Innovation has comprehensive primary care programs. These programs allow the physician practice to increase capacity and skill sets by providing a monthly fee that is designed to allow practices to bring in nurse care managers, pharmacists, integrated behavioral health, staff to support assistance in patients with disadvantaged social determinants of health, for example. This promotes more effective panel management and greater access to primary care. It allows practices to be ready to assume the obligations of accountable care payment programs. They also promote partial capitation for primary care services, so practices are not just focused on visit volumes. These programs should be rapidly expanded for practices that wish to enroll in them. They implement the National Academies of Sciences, Engineering, and Medicine⁴ recommendations to strengthen interprofessional teams and ensure that care teams reflect the diversity of the communities they serve. However, expansion will require infrastructure support, funding, and attitudinal shift.

⁴ 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. <https://doi.org/10.17226/25983>.

Comprehensive Primary Care Plus (“CPC+”) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. This program not only strengthens primary care for all beneficiaries but is also designed to meet the specific needs of the chronically ill patient. Currently, participation is limited to certain geographic regions and not all practices that hoped to participate were selected.

Beyond CPC+, there are many successful models and innovations that help achieve the goal state for primary health care. We urge the Committee to review [*“Complexities of Care: Common Components of Models of Care in Geriatrics” \(2022\)*](#) as well as the models listed in the NASEM’s report, [*“Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care \(2021\)”*](#). [*“Complexities of Care, published in the Journal of the American Geriatrics Society*](#) explored the common components of models of care in geriatrics when caring for older adults with “care complexity.” The article defines care complexity in older adults, reviews healthcare models and the most common components within them and identifies potential gaps that require attention to reduce the burden of care complexity in older adults. While these models show great promise, most are, unfortunately, limited in scope and not universally available.

2. Reinstate the Primary Care Bonus Payment

As part of the Affordable Care Act (ACA), Medicare implemented a 10 percent bonus payment for primary care physicians for five years. The bonus payment expired at the end of 2015. The AGS urges Congress to consider restoring the payment indefinitely, which 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. The current shortage is the result of under-funding of primary care, which has made careers in primary care medicine unattractive to graduating physicians because of the relatively low incomes they generate compared to other medical fields. Primary care also has greater levels of responsibility between visits, in quality reporting, and in dealing with the shortcomings of electronic health records (EHRs).

3. Expand Telehealth

Medicare beneficiaries need permanent access to telehealth and practices need adequate payment for it. 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 visits⁵ and create access for those that previously lacked the ability to get medical and behavioral healthcare needs met. Payment must be adequate for these services. These services require the use of clinical staff and indirect practice expenses. Insufficient payment undermines a practice’s ability to provide the services.

4. Revamp Quality Measurement

AGS strongly encourages the development and deployment of quality metrics related to patient goals and treatment burden. Medicare should create and adopt a more holistic approach to quality

⁵ Cuellar A, Pomeroy JML, Burla S, Jena AB. Outpatient Care Among Users and Nonusers of Direct-to-Patient Telehealth: Observational Study. J Med Internet Res. 2022 Jun 6;24(6):e37574. doi: 10.2196/37574. PMID: 35666556; PMCID: PMC9210206.

measurement in older adults with multiple chronic conditions that does not rely on single disease payments. Elements of such a system could be modeled upon the 4Ms of age-friendly care with an emphasis on what matters to the person.⁶

Thank you for your 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 MACRA 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 you to achieve these goals as you develop legislative solutions.

⁶ Institute for Healthcare Improvement. "[Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults](#)" (2020).