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

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Submitted via regulations.gov

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Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1848–P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244–8016

RE: Request for Information: Redesigning Primary Care to Make America Healthy Again

Dear Dr. Oz:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to respond to the request for information (RFI) from the Centers for Medicare & Medicaid Services (CMS) on redesigning primary care to make America healthy again. AGS has submitted comments separately about specific policy issues in the 2027 Medicare Physician Fee Schedule (MPFS) proposed rule.

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence and quality of life of all older adults. Our 6,000+ members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician associates, pharmacists, and internists who are pioneers in serious illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. AGS believes in a just society, one where we all are supported by and able to contribute to communities where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. AGS advocates for public policy that promotes the health and independence of older Americans, with the goal of improving health, quality of life, and healthcare systems serving us all as we age.

Below we comment on each section in the RFI but offer some initial cross cutting comments to frame our responses. A major issue that affects both patients and practitioners is the complexity of our healthcare delivery system. Innovations in Medicare payment should seek to reduce

complexity or at least not worsen it. An example of an effective innovation was the introduction of the Advanced Primary Care Management (APCM) codes. The code level selection is based primarily on information readily available to the billing practitioner and the requirement to either report the Value in Primary Care MIPS Value Pathway (MVP) or participate in an accountable care organization (ACO) makes accountability straight-forward. APCM supports primary care without increasing administrative burden, which is one of the major factors that keeps many new clinicians from entering primary care.

In evaluating primary care reforms, CMS should remember that medicine, especially primary care, is not just about information technology, pharmacology or devices. It is about relationships. An "innovation" that harms relationships may well have a net negative effect on health and the costs of healthcare. For example, while electronic medical records (EMRs) have offered some benefits for quality measurement and care coordination, much of the promise of the EMR has not been realized and its use is a major factor in increasing both the cost of delivering care and administrative burden on primary care practices.

This RFI focuses heavily on the incorporation of artificial intelligence (AI) into primary care. Technology, including AI, is a tool and adoption rates will vary by practitioner, health system and by the tool itself. Society as a whole is just beginning to understand the impact of AI and it will evolve faster than CMS' ability to measure all of the consequences of its use. It is not clear that adoption of AI will occur more rapidly in primary care than other types of healthcare or that the benefits of AI will outweigh its costs in healthcare generally and primary care specifically. In considering primary care reforms, CMS should focus on improvements that support building robust patient-clinician relationships and avoid prematurely incentivizing adoption of a specific type of tool.

The RFI also asks about primary care capitation. Any effort to incorporate capitation into primary care payment must be well designed and carefully considered. Failed primary care capitation would exacerbate existing pressures on primary care clinicians and worsen the primary care crisis. Capitation should not simply repackage current for-fee-service (FFS) payments without providing new infrastructure support. Participation in capitation should be voluntary and payments should be directed to the primary care practice which can then invest in additional capacity in the manner most appropriate to that practice's needs.

Capitation should be for primary care services, sometimes referred to as "subcap". We believe total cost of care capitation exposes primary care to excessive risk and forces practices to partner with a capital resource. Total cost of care growth that significantly outpaces the Medicare Economic Index (MEI) reflects newer treatments in areas such as oncology and greater use of the hospital outpatient department. These are not factors under significant control of primary care. Therefore, primary care is subjected to insurance risk and not care management risk. Primary care is only 5% of total cost and the major growth in cost is not due to primary care. In fact, cost growth in primary care should be viewed as a positive correction for historical underinvestment. Capitation amounts should be risk adjusted to reflect the resources required for team-based primary care. Any adjustments in payments related to primary care services provided by clinicians other than the practice receiving capitation must be accurate and not use the erroneous Primary Care First (PCF) "leakage" methodology. CMS must improve the taxonomy for advanced practice clinicians to more

accurately attribute costs to primary care practices. Most nurse practitioners and physician assistants now work in specialty practices but continue to be identified as primary care clinicians under the CMS taxonomy.

Below we address CMS' specific questions.

A. Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule

a. <u>O/O E/M Visits</u>

1. What updates to the HCPCS code G2211 policy (or the proposed modifiers, MOD1and MOD2) should CMS consider to ensure the clinician billing HCPCS code G2211 (or proposed modifiers, MOD1 and MOD2) is serving as the focal point for beneficiaries, and that the practitioner is also considering preventive care, risk factor reduction, and other services necessary for coordinating the care of beneficiaries who have a complex condition?

We do not believe updates to G2211 or the proposed modifiers MOD1 and MOD2 are required at this time. Fundamentally, the complexity adjustment is designed to support continuity relationships. Allowing G2211 to be reported with home/residence visits and for visits provided on the same day as preventive services were major improvements that AGS applauds. We agree that the proposed proportional approach, rather than the current flat fee approach, is logical and better reflects costs associated with the complexity of care. AGS recommends that CMS adopt this change for 2027. For future rulemaking, CMS should consider whether refinements are needed to better reflect the complexity of care furnished to high need patients, such as those typically seen by home-based practices. We expect that the cost of caring for home-based patients is roughly twice that of patients seen in O/O E/M visits and an appropriate adjustment would be comparable to that of MOD2.

The use of G2211/MOD1/MOD2 in primary care is straightforward and appropriate. We believe that primary care clinicians routinely consider preventive care and risk factor reduction, use even brief encounters to check for care gaps, and coordinate care between visits. Specialists typically coordinate with primary care, and this should be an explicit expectation whenever G2211 is reported by a specialist. Attempting to be more specific about conditions and documentation is unlikely to reduce any perceived improper use and could increase burden on those who are providing excellent continuity care.

2. Given the broad range of changes CPT makes annually, we recognize updates to the CPT code set to reflect distinctions among O/O E/M visits by the function of the visit (longitudinal, acute, or consultative) may have significant advantages within the current billing and coding ecosystem. However, absent a change in CPT coding, should we consider the possibility of creating G codes to better recognize distinction between and among these kinds of visits? If so, what categories should we consider? How could we effectively differentiate longitudinal care visits from acute care visits? What number of levels would be needed and for which settings of care? Should we use existing CPT codes as templates? How should we consider valuing

these potential G-codes under the PFS, including the basis for the standard inputs: work RVUs, time values, specialty mix for utilization crosswalks, direct PE inputs, etc.? How would practitioners balance and manage the increasing number and complexity of these codes?

CMS should not consider creating G codes to distinguish between longitudinal, acute, and consultative E/M visits. CMS does not articulate what the potential "significant advantages" that may be associated with this approach, but the sheer number of questions asked demonstrates why any benefit would likely be outweighed by administrative burden, compliance challenges, and costly implementation. Having two sets of codes for E/M services (G codes and CPT codes) would create considerable confusion and administrative headaches, especially for individuals with multiple forms of health insurance such as double commercial coverage, traditional Medicare and "Medigap" coverage, Medicare and Medicaid, etc. CMS has already effectively created multiple categories of E/M services without having to change the base coding structure. G2211 differentiates between acute and longitudinal care. Within longitudinal care, the dual criteria also differentiate between primary care, wherein almost universal use of G2211 is appropriate, and specialty care, wherein the patient must have a serious or complex condition to report G2211. The final category of E/M service is the post-operative visit furnished within the global period of surgical service. Global post-operative visits are paid differently than stand-alone E/M services.

We do not believe broad changes in the E/M code structure are needed. Any targeted changes tied to E/M can be pursued through rulemaking or the CPT process, as appropriate. A dual coding system should not be considered, especially absent specifically stated concerns or goals.

3. If CMS were to propose longitudinal or primary care visit types, what should the service period be? Should subsequent care management services be bundled in? If so, for what period of time? Which care management services might be included?

As noted above, we do not believe CMS should consider creating codes for longitudinal or primary care visit types. We understand that CMS is considering primary care capitation payments and urge CMS to develop any capitation methodology by drawing on experiences with primary care payment models and the success of the APCM codes. We provide comments on primary care capitation in response to that section of this RFI.

We emphasize that the APCM codes have done an excellent job of bundling care management, and we expect to see increasing adoption and success in promoting advanced primary care. CMS should consider whether refinements to the APCM model could further improve payment accuracy, such as better identifying high need patients for whom the cost of coordinating and managing care is greater than other patients but who may not be Qualified Medicare Beneficiaries.

4. Are there specific data on the resources used in furnishing longitudinal care, acute care, or consultative services CMS should consider for potential categorization of O/O E/M services?

We do not believe there are data sources that differentiate resource used based on longitudinal, acute, or consultative services. These are broad categories of services and on any given day, most practices typically deliver both acute and longitudinal care. Separating resources out by types of

care would require looking at practices that only deliver limited services such as an urgent care center which may not be representative of practice expense for clinicians who furnish more comprehensive care. CMS did not recognize the CPT consultation codes because the distinction between consultation services and other E/M visits was difficult to determine. AGS believes that the current outpatient E/M codes which differentiate levels based on time or medical decision making (MDM) and are enhanced by G2211 already account for resource differentials.

b. <u>Care Management Code 'Family'</u>

1. What additional requirements should CMS consider to reduce fraud, waste, and abuse in care management services? Specifically on the following:

++ What is the appropriate 'trigger' or initiating visit for care management services? How would this change if it were an initiating visit vs. another event?

++ Should CMS consider changing supervision requirements in care management services to prevent fraudulent billing of care management services? What is the appropriate supervision requirement for care management services?

++ How should data submission to CMS change to verify services are received?

++ What guardrails should CMS consider to prevent inappropriate billing?

++ What proportion of care management services must be delivered by the supervising provider, versus auxiliary personnel?

Absent specific audit data, AGS believes fraud, waste and abuse are not an issue with most practitioners who personally perform care management services. Legitimate practices almost certainly under report these services because of concerns about cost-sharing and documentation requirements. For services furnished by auxiliary personnel, the integration requirements may need to be stronger than the current requirement that the clinical staff managing patient care have a subjectively meaningful relationship with the supervising and reporting practitioner. Smaller practices may need a source for external care managers such as within an independent practice association (IPA), a community-based organization (CBO) or an affiliated hospital system. This is especially true when they participate in risk-bearing contracts with Medicare or Medicare Advantage. However, CMS should evaluate how external care managers are being utilized. We are suspicious of entities that enroll populations within a practice with a business plan promoting increased practice revenue. An analysis of the ratio of beneficiaries who have a reported E/M as the denominator and those with any care management service in the year as the numerator may help CMS identify potentially inappropriate use. The type of practice would need to be considered in any such quantitative screen as a geriatrics complexity practice would have different reporting than the typical adult medicine practice.

All patients currently have an initiating visit for care management services and requiring another trigger such as an emergency department visit or a medication change is unnecessary. The current code structure adequately addresses the practitioner/auxiliary staff proportions. General supervision for care management services remains appropriate but additional guardrails are needed for use of external entities. CMS could require that any staff not employed by the practice

be engaged by an agreement using specific CMS approved language that outlines the relationship between the entity and the practitioner and the integration requirements. Under this scenario, fraud would be easier to prosecute and abuse may be curtailed. CMS does not suggest specific additional data submission requirements, and we do not believe any are necessary. Additional requirements add administrative burden which usually hurts honest practitioners and does little to reduce fraud, waste and abuse.

2. Are there specific data on the resources used in furnishing advanced primary care, which incorporates population health management, enhanced communication technology, and longitudinal care management?

The National Academies of Sciences, Engineering, and Medicine (NASEM) has a standing committee on primary care that surveils the primary care field and discusses relevant primary care data. CMS should consider NASEM data and publications. In addition, the Rhode Island Office of the Health Insurance Commissioner recently released a report to the General Assembly that details costs of primary care delivery based on a review by Milliman and provides information addressing this question.[1]

3. To what extent are the current care management codes duplicative? Are there efficiencies to be gained in simplifying the current care management code 'family' into a more efficient code set? To what extent would this improve appropriate utilization of care management services?

The care management codes have had a complex evolution. The codes originated with a desire by CMS to recognize patient-centered medical homes and comprehensive care planning for certain beneficiaries. CPT then created Transitional Care Management (TCM) codes and Complex Chronic Care Coordination codes. CMS and CPT worked together and eventually created the Chronic Care Management (CCM) codes. To recognize disease specific care management by specialists, CMS also created Principal Care Management (PCM) G codes and Behavioral Health Integration and collaboration service codes, which were later adopted into CPT. Collectively, the care management family of codes improves care coordination, manages chronic diseases and supports the needs of older adults with complex conditions. Refinements over time have included differentiating between physician/QHP services compared to clinical staff services and the creation of add-on codes to report additional time within a calendar month. CPT has also created codes for remote monitoring and management services.

We believe people know how to properly use the existing codes although the need to track time is a major challenge and may limit practitioners' ability to report the codes. More than a decade after the adoption of TCM and CCM, billing for care management remains complex with labor intensive work arounds because of EMR limitations. Many practitioners do not report the care management

[1] State of Rhode Island Office of the Health Insurance Commissioner. Primary Care Rate Review - Final Report, September 1, 2026.

codes because of concerns about cost sharing and a general failure of EMR systems to capture and report a service that does not occur on a specified single date.

The care management code set could be simplified but that would require accepting the loss of what were heretofore considered key differentiators in the type of care provided from supporting multiple chronic conditions to intense monitoring of a single, highly complex condition to preventing complications and reducing readmissions following a hospital stay. Any change would be unlikely to significantly promote appropriate use nor discourage inappropriate use.

The APCM codes do significantly simplify reporting but are limited to advanced primary care practices.

4. If reducing the number of care management codes would not increase efficiency or utilization of appropriate services, how else can CMS standardize the requirements across the care management codes?

The requirements are generally standardized across the care management codes. There is planned differentiation based on whether the service is comprehensive primary care, single condition care (high risk illness or behavioral health) or remote monitoring management. The APCM bundling was a major positive breakthrough for advanced primary care practices that greatly simplified reporting.

5. As care management becomes increasingly technology-enabled, how should CMS consider changing the code family and their relative valuations? How can CMS ensure that automated billing leveraging technology reflects actual care delivered to beneficiaries by care teams or practitioners?

The current code structure does not recognize care management performed by interactive software and any reporting of the "staff time" of a machine is incorrect coding. How CMS accounts for and values care that involves software is a matter that has been under consideration for many years and is not specific to care management. Once CMS settles the broader issue of incorporating software into practice expense, CMS can determine whether it should affect the valuation of the care management codes, if at all.

6. Should CMS create 'technology-enabled care management' codes or a 'two-track' approach to care management? How should we ensure these codes are appropriately differentiated?

We do not believe that a two-track or other approach to technology-enabled care is needed at this time. A new code or codes may eventually be required to describe a care management service that is largely technology-driven and not human-based. CMS will first need to resolve how it addresses the resource costs of paying for any technology-enabled service and software costs. Current coding and valuation for care management should not be disrupted while CMS addresses those issues. Further, machine-based care management is not yet in widespread use and how it will be used is not settled. We have seen an evolution in other areas such as computer assisted lesion recognition in mammography, where use of a technology is initially considered an added service but eventually becomes the typical service.

B. Payment Implications of Technology Enablement of Primary Care

a. <u>Changes to Primary Care and Care Management Due to Technology and Clinical AI</u>

We reiterate our position above that the hallmark of excellent primary care is the relationship with the patient (and caregiver when needed). This is especially true for the high cost, multimorbid Medicare beneficiary. Technology, including AI, is a potentially valuable tool to be used in furnishing primary care but it is just now being more widely deployed and understood. CMS should avoid prematurely incentivizing or disincentivizing use of a particular intervention or technology given the inherent risks of harm and shortcomings due to incorrect information, bias, automation overreliance, and lack of sufficient safeguards, risks that are heightened for older adults.[2]

1. Our understanding is that clinical documentation and clinical decision-support tools are currently the most commonly used applications of AI in primary care. Does this reflect current practice? In particular, are there additional clinical AI tools and new technologies that are frequently being used in primary care settings with high accuracy, demonstrated safety, and clinical outcomes reported? If so, please describe how they impact the clinical workflow and the beneficiary experience.

We believe the most commonly used AI tool is ambient listening and transcription, although it may not yet be typical, especially with smaller practices. Ambient AI transcription generally allows patients to feel their practitioner is more engaged with them rather than a computer screen. However, as described in recent JAMA articles, while documentation quality is likely improved and some burnout reduction may be achieved, gains in efficiency are modest at best.[3, 4] Clinical decision support (CDS) is limited for primary care, although some alerts may be available, particularly as suggestions provided by AI may not take the patient's priorities into consideration and lead to unnecessary treatments.[5] Use of AI for literature search and guidelines at the point of care is common across specialties, including but not limited to primary care, and often used resources, such as Up to Date and Open Evidence, have adopted AI. Other uses of AI include utilization review/prior authorization tools and summarizing medical records, including external records obtained with Fast Healthcare Interoperability Resources (FHIR) applications. The most rapidly adopted use because of the financial return is for risk adjustment coding. AI can "scrape" notes for data to suggest more accurate diagnosis code reporting. Again, these uses are not specific to primary care. AI may be used to support shared decision-making and patient education for some conditions but not widely. It may be less useful when multiple chronic conditions are present, for patients with variable cognition and function, in high stakes decisions and care, or if

[2] Bharija A, Khan A, Pavon JM, et al. Generative AI in the care of older adults: a position statement from the American Geriatrics Society. *J Am Geriatr Soc.* Published online July 21, 2026. doi:10.1111/jgs.70566

[3] Rotenstein LS, Holmgren AJ, Thombley R, et al. Changes in Clinician Time Expenditure and Visit Quantity With Adoption of Artificial Intelligence–Powered Scribes: A Multisite Study. JAMA. 2026;335(16):1408–1417.

[4] Husa RA, Haggerty J, Nute AW, et al. Ambient Artificial Intelligence Use and Clinician Documentation Burden, Productivity, and Efficiency. JAMA Netw Open. 2026;9(5):e2615762.

[5] Shortliffe EH, Sepúlveda MJ. Clinical decision support in the era of artificial intelligence. *JAMA.* 2018;320(21):2199-2200. doi:10.1001/jama.2018.17163

interprofessional teams or multiple stakeholders are involved.[2] All these resources and uses come with a financial cost that is not built into current direct practice expenses.

These resources may also introduce errors into clinical practice. Clinicians are directed to use extreme caution with publicly available resources due to risk of privacy violation and hallucinatory or false information and results. In all cases, human clinician expert judgment is required in addition to the AI output and the degree to which care, outcomes, and safety is improved remains to be seen. For example, in a recent study, intentionally incorrect care suggested by AI was too often accepted and clinicians did better overall without AI.[6]

2. If you are a physician furnishing primary care services, how has your practice been impacted or how do you expect it will be impacted by clinical AI tools?

AGS is a specialty society representing over 6,000 members. We feel confident practices are currently being impacted and expect this will only increase over time. The impacts are and will continue to be both positive and negative.

3. How has incorporating technology and AI tools impacted the resource costs associated with primary care practice, in terms of the time and intensity of services delivered?

AI increases practice expense costs. It does not currently have a clear and significant impact on time and intensity of service delivered.

4. How has the implementation of clinical AI tools led to improvements in the quality of care, or reduced downstream costs? In general, please cite any evidence available for your comments.

Based on the experience of our members, it is too early to confidently assess the impacts of AI on quality of care in real world application. It may have the potential to positively impact quality of care and could potentially reduce unnecessary care. It could increase downstream costs related to better care. Available evidence is insufficient at this time to determine the impact.

5. If these tools are increasing productivity, what are clinicians and other health professionals doing with the additional time/bandwidth created? Are you seeing more patients in visits, engaging more with population-health management or care management, accomplishing administrative tasks, or something else?

The net time saved by use of AI tools is modest at best in primary care generally and specifically for complex geriatrics care. Documentation is improved, which allows better population health management and an ability to engage in value-based care. However, AI innovations and algorithms inadequately address the "5Ms" of geriatrics care. The 5Ms are mind, mobility, medications, multi-complexity, and what matters most to the individual. They provide a comprehensive framework for caring for older adults. Of the 5Ms, AI would be best suited to facilitate medication review and least

[6] Kücking, F. *et al*. Impact of AI recommendation correctness on diagnostic accuracy in clinical decision-making. *Int. J. Med. Inform*. 207, 106223 (2025).

effective in what matters most. Relationships and what matters most are at the heart of good geriatrics care and AI cannot perform those functions.

6. How do you ensure patient data and privacy is adequately protected during use of these tools?

Practitioners must use HIPAA compliant tools and devices and they are strongly instructed to not use other tools. The need to use compliant tools and devices is one reason that use of AI represents additional practice expense cost. Additionally, legitimate concerns about AI autonomously crossing boundaries are unresolved and will limit confidence in its use. Robust and transparent data use policies as well as cybersecurity for AI use are critical.

Standardized frameworks for Intellectual Property (IP)-sharing, privacy-preserving analytics, and responsible model stewardship (e.g., model cards, usage audits) may further support innovation without compromising privacy, trust, or transparency. In the older adult population, it may be helpful to create aging-specific ethical frameworks that address consent capacity, data sharing preferences, surveillance, and autonomy in AI-assisted decision-making, while considering the importance of delivery of person-centered care that facilitates cross-study research and evaluation of best practices in clinical care.

7. Please describe areas where clinical AI tools in primary care are not well captured in the current coding and payment system and suggest how these may be incorporated to facilitate high-value, technology-enabled primary care.

The cost of AI tools is not adequately captured in indirect or direct practice expenses, but as we have noted above, this gap is not specific to primary care. We do not believe coding changes are needed at this time. It remains to be seen whether time and Medical Decision Making (MDM) are affected by use of AI such that unique coding or different code valuations are necessary, compared to long used resources such as standard transcription, Clinical Decision Support (CDS) and other clinical information resources. We have heard anecdotal reports from members that ambient listening does not reduce time given the need to review transcripts in order to ensure that AI has appropriately summarized the discussion and any decisions that were made. Coding describes established practice as it is typically performed. At present, the use of AI is variable and diverse and new codes are not needed or appropriate.

8. What can CMS learn from how private payors have approached payment and coverage of clinical AI in primary care? How are they monitoring for safety, privacy, fraud, waste, and abuse?

Private payers have not demonstrated innovative approaches to AI adoption, other than in harvesting data for hierarchical condition categories (HCCs) and prior authorization tools. Many private payers perform care management and may use AI for predictive modeling, just as they have used other methods of predictive modeling for years. AI may increase the level of sophistication applied to these tasks, but it is not a substantive change in operations. Plans implement federal requirements for privacy standards, similar to those required prior to the introduction of AI. Many private payers have algorithms to identify aberrant billing patterns that may suggest fraud, waste, or abuse but it is unclear how effective those tools are in accurately identifying bad actors. There

are significant concerns about inappropriate E/M downcoding by payers driven by use of those tools.

9. How could private payor coverage of clinical AI in primary care streamline or otherwise facilitate CMS coverage or payment?

Practice change is facilitated when there is payer alignment, such as in quality measurement. This could be true with AI as well. But leadership in covering clinical AI is lacking as plans are averse to any additional expense without clear information that costs overall will be moderated.

10. From an outcomes-based perspective, how should CMS evaluate and monitor the impact of technology-enabled care in primary care?

CMS should monitor unintended harms (e.g., errors of omission), beneficiary satisfaction, and whether care is consistent with the patient's personal care goals, because desired outcomes may vary by beneficiary. Payment models for AI-assisted interventions should also be evaluated. Data scientists and quality measurement experts could suggest possible considerations and any recommended outcomes measures should go through a review process similar to what the National Committee for Quality Assurance (NCQA) does with HEDIS®. We expect the literature base to grow on how interventions such as patient messaging, CDS tools, etc. affect outcomes such as use of preventive services or hospital readmission. AI could help reduce use of low value care, if there is consensus about what services are considered low value care. AGS has developed and maintains the AGS Beers Criteria® of potentially inappropriate medication (PIM) use and the impact of AI on PIM rates would be of interest.

11. What outcomes would accurately capture whether these technologies have improved or negatively affected primary care practice for both clinicians and beneficiaries? Are there different outcomes for short-term and long-term impacts?

We describe recommended or possible outcomes above. We do expect short- and longer-term outcomes to be relevant and different.

12. What type of outcomes data should be shared with CMS? For example, to what extent would submission via Fast Healthcare Interoperability Resources (FHIR)-based APIs of clinical outcomes or activity sets be an appropriate approach by which to tie payment?
    - What submission frequency and formats would be most appropriate?
    - How can we collect those outcomes in a way that minimizes administrative burden?
    - Are there other payment structures, beyond outcomes-based and prospective (which will be discussed in the next section), that would be more suited to the unique nature and impact of these technologies? If so, please describe.

Considerable effort has been expended in data collection on outcomes and quality metrics for close to 20 years. The ability to efficiently collect data in a manner that reduces burden on clinicians and practices warrants continued efforts, and we believe will ultimately be successful. That said, AGS has long had concerns regarding the delineation of a positive or negative outcome

defined by care for a single condition. Use of quality data for scientific advancement is different than use in pay for performance, accreditation, and payer participation status approval. A tool with approximate accuracy is acceptable when it is used commensurate with its degree of precision. A tool with the same accuracy when used inappropriately could bankrupt or otherwise adversely affect a clinician or safety net provider and such outcome is not acceptable.

AI simply brings longstanding issues with quality measurement to the fore because simpler, more efficient measurement may mean more measurement. Measurement in itself is of limited value. Improvement in care quality requires multiple elements: feedback loops, a focus on a small set of processes at any one time, healthcare provider buy-in, and financial support of system improvement. APCM is an example of appropriately recognizing the current resource costs of better care while simultaneously stimulating universal transition to an advanced primary care practice.

b. <u>Technology and AI-Augmentation in Primary Care via the Medicare AWV</u>

1. How can CMS improve the effectiveness, efficiency, personalization, and beneficiary experience of the IPPE and Medicare AWV?

AGS has long supported AWV (and IPPE) services because they include assessment of important areas such as cognition, sensory challenges and functional status. The typical patient seen by our members has limited primary preventive needs, but the AWV promotes a whole person assessment and discussion of care/health priorities. Technology could simplify data collection and enhanced shared goal decision making during the AWV but ultimately the best value of the AWV is that it fosters a relationship with the practitioner's care team. The exams are best performed as a team-based service. We believe these services should only be allowed when associated with continuity of care practices – for example, beneficiaries should not receive an AWV in a mobile van that also bills Medicare for "screening" services. Worse would be an AWV performed by machine without it being part of a primary care practice. We do not recommend that CMS impose new requirements for these services at this time as we are not aware of technology driven "AWV mills".

2. Which, if any, AWV components are being delivered (or could be) more efficiently delivered through technology and clinical AI-enabled tools? Please comment on how technology is being used today within the AWV, how that has changed over the last year, and how the community sees that changing over the next couple of years. Which activities require direct involvement by a physician, qualified non-physician practitioner, or medical professional under physician supervision?

We do not believe there has been significant change over the last year in how technology is used. Over time, prognosis tools could guide better recommendations and use of preventive services, such use of prognostic AI tools would only be appropriate in the context of patient-centered goal setting with the clinical team.

Data collection and shared decision-making tools could improve efficiency and quality. In some cases, the tools could help stratify patients for care management. For example, we know IADL/ADL is a major factor in accurate risk adjustment, but it is not routinely collected and applied in a consistent manner. AI may support accurate collection of IADL/ADL data and allow analytics to be

programmed. However, all clinical activities require direct involvement of a clinician for an accurate and meaningful assessment and care plan. It would be inappropriate, for example, to allow automated collection of data for the Patient Health Questionnaire-9 (PHQ9) and then have an agentic AI make a behavioral health referral and enroll a beneficiary in online cognitive behavioral therapy and insomnia therapy programs based on the results. The assessment of the PHQ9 and decision to refer requires the judgement of a clinician. The appropriateness of therapeutic tools and which tools to employ requires direct oversight and judgment of a clinician.

3. Could AI-enabled AWVs improve health outcomes that prior studies have found to be inconclusive?

We believe this may be possible, but additional study is needed to identify the specific services and associated outcomes that may be improved. Even recommended preventive services have some limitations on clinically relevant outcomes.

4. What evidence should CMS consider regarding whether technology or clinical AI-enabled AWVs improve clinical usefulness of visit and clinical outcomes, beneficiary reported outcomes, or utilization?

CMS should consider clinical outcomes and utilization in evaluating AI-enabled AWVs. Research around changes in the use of preventive services and the application of preventive services to individual clinical risk factor assessment or in low-value downstream utilization are of particular interest. It is not clear how CMS would measure the clinical usefulness of an AI-enabled AWV compared to a non-AI-enabled AWV.

5. What existing statutory, regulatory, enrollment, billing, supervision, documentation, data-sharing or other requirements may create barriers to an AI technology company delivering AWV-related services while employing or contracting with appropriately licensed physicians or other medical professionals to perform AWVs? To what extent may program integrity concerns exist with these models?

AWVs are important elements of longitudinal care and help establish and maintain the ongoing relationship that is the cornerstone of high-quality primary care. AWVs should be furnished by clinicians who are engaged in regular continuity care with the patient. Technology companies can supply a tool for clinicians to use in furnishing services, including AWVs, but we do not believe they can or should deliver AWV services. An AWV technology entity that contracts with a clinician to oversee a robotic AWV or with other clinicians who are only nominally involved in the patient's care may increase AWV uptake and thus costs but not provide any clinical benefits. Furnishing the AWV in this manner would also deprive the continuity practitioner from providing the service and bolstering the clinician/patient relationship. Such a scenario also lends itself to engagement in or ordering of other services that are of marginal value and subject to misuse such as outside vendors furnishing care management and remote monitoring. AWV providers who have no continuity relationship with the patient tend to also perform low quality, low value and unnecessary screening or diagnostic services.

CMS should also explicitly prohibit AWVs by non-continuity of care providers that are evaluating the patient's condition(s) for HCC/RAF coding intensity. If a Medicare Advantage plan or ACO wishes to do an annual assessment for ICD-10 capture, it should not be reported as an AWV.

6. In what circumstances should CMS consider payment or policy changes that would allow technology-enabled organizations, including AI technology companies, to participate in AWV delivery models, either directly or through partnerships with Medicare-enrolled providers or suppliers?

The experience with the Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) codes suggests that CMS should be very cautious about proposing changes in payment rates or policies to incentivize delivery models that rely on external vendors, including AI technology companies. CMS should provide robust response to the comments received on this RFI to enable stakeholders to offer meaningful feedback on the approaches that may be under consideration in future rulemaking.

7. How should CMS evaluate whether AI-enabled AWVs are improving outcomes rather than merely increasing AWV volume, documentation completeness, coding intensity, or low-value care follow 'cascades' of services? Specifically, for which outcomes should CMS hold technology companies accountable?

CMS should evaluate measures that matter, such as beneficiary satisfaction related to care goal congruity. As noted above, assessments that are intended to improve HCC/RAF coding intensity should not be reported as an AWV. CMS should seek to define measures that assess the degree to which the AWV is integrated into the primary care practice. For example, completion rates for preventive services among patients who receive AI enabled AWV, standard AWV and no AWV (but who used some primary care office services) could be compared.

8. How could CMS optimize information sharing from AWV throughout the duration of the primary care relationship? Where could AI-enabled tools facilitate this process?

The AWV should be furnished by a primary care clinician which substantially reduces the need for additional information sharing. However, the AWV can help identify patients that would benefit from care management services and other interventions to improve functional status. The results of the AWV could be built into Health Maintenance fields and CDS tools about suggested interventions. The AWV does provide a vehicle for sharing patient information with specialists, facilities and support organizations (e.g. Community-Based Organizations (CBOs)). An AI enabled template and information transfer mechanism is potentially useful for this function.

C. Developing Prospective Payment in the Shared Savings Program

a. <u>ACO and ACO Participant Readiness</u>

1. To what extent are Shared Savings Program ACOs and ACO participants, and their associated health care providers (referred to herein as "ACO providers/suppliers"), ready to take on capitated payment arrangements? Please describe ACO and ACO participant level of readiness for each of the following:

++ Hybrid capitation (a combination of capitated and OM payments).

++ Full capitation for primary care services (that could enable ACOs to provide downstream payments to ACO participants).

++ PBPs as a fixed percentage of expected OM claims.

We are interested in understanding what operational changes ACOs would need to undertake to effectively receive, manage, and distribute capitated payments. Please describe any barriers or conditions – legal, financial, or operational - that could affect an organization's readiness to participate in each type of arrangement.

We do not believe that CMS should seek to make primary care payments through the ACO, whether those payments are made on a FFS basis or capitated. It is already in the interest of ACOs to recruit good primary care clinicians, but making capitation payments to the ACO makes the primary care practice dependent on the ACO and is associated with negative power dynamics. The way to most effectively support primary care is to provide additional resources directly to the primary care practice rather than to another entity who may use those resources to support goals unrelated to primary care. Capitation through ACOs would require that legal, financial and operational mechanisms be created, which will result in administrative costs for the development and implementation of those mechanisms.

CMS should not establish capitation as a percentage of expected Original Medicare total cost of care claims. Under the ACO model, this approach creates misaligned incentives. If the primary care practice saves money, it sees its capitation decrease over time while conversely, higher costs would increase capitation. However, many states have created primary care spend targets that relate to increasing primary care spending relative to the total spending on healthcare. These programs are appropriate and bolster primary care. They are recalibrated regularly and the goal is to increase investment in primary care whether by primary care sub capitation or FFS payments or a hybrid payment.

2. If an ACO received capitated payments for primary care services furnished by ACO providers/suppliers billing through the TIN of an ACO participant (as defined in § 425.20), what organizational and programmatic goals would the ACO seek to advance with those payments? For example, we are interested in understanding whether ACOs would use capitated payments to expand the scope or capacity of existing care coordination and population health programs, or whether capitated payments would instead enable ACOs to operationalize new care delivery initiatives. Please describe the specific types of initiatives that ACOs would seek to implement, and how ACOs would ensure that these payments went to support primary care practices directly.

As noted above, we are concerned that payments made to the ACO would not necessarily reach the primary care practice. The ACO may retain too much of the professional payment either as a risk reserve or to cover centralized services. The current ACO structures already have incentives to succeed in cost savings and quality. An ACO professional needs to support the goals of the ACO and contribute to services that promote the goals of the ACO. Failure to do so reduces the

likelihood of receiving shared savings and/or would be done at the expense of the ACO partners. ACOs invest in activities such as care management, transitions management, pharmacist medication reviews, quality performance infrastructure, community paramedicine, integrated behavioral health, etc. Implementation of these initiatives may vary, depending on practice size. For example, a multi-FTE clinician practice might have their own pharmacist, whereas a 1-person practice would lease pharmacist hours from the ACO. Some services would typically be centralized such as community paramedicine and home visit services. CMS should pay the practitioners directly and then centralized services can be billed or taken from shared savings, as appropriate. Making all ACOs become a claims processor or payroll entity is not necessary, even if some ACOs choose to perform those roles, as permitted by CMS and their professional participants. Capitation can create flexibility and shared savings are commonly reinvested in strengthening primary care and care management. But any payment model must be adequately funded to achieve its goals.

b. <u>Eligibility for Participation</u>

1. Should CMS limit access to capitated payment arrangements exclusively to ACOs participating in two-sided risk tracks (BASIC tracks C, D, E or the ENHANCED track), or should all ACOs be eligible to receive some form of capitated payments, regardless of the ACO's participation track? ACOs participating in two-sided risk tracks must establish a repayment mechanism prior to the start of an agreement period, and we are interested in whether similar proof that an ACO could repay losses should be required as a condition for receiving capitated payments, even for ACOs in one-sided risk tracks.

Primary care generally makes up a small portion of total ACO spending and therefore primary care capitation does not create high risk for ACOs. The value of primary care capitation within an ACO is that it supports elements that are inherent requirements related to access, care management and quality that are necessary for the ACO to succeed. There is a small but real risk in capitation outside of an ACO that a practice takes the money and does not deliver services, though partial, rather than full, capitation would mitigate this risk. If all PCP payments (full capitation) are made through the ACO, it would be essential to be sure the ACO is solvent and can pay the participant professionals. If payment is through the ACO, then the ACO would need to reserve the CMS required repayment mechanism plus at least 5% of the total expected medical expense, the share of total cost typically associated with primary care. This would likely increase financing costs and reduce the ability to send money to the participant professionals. The resulting need for additional regulation and monitoring is another reason we believe payment through the ACO is not appropriate.

CMS should also consider other models such as the Independence at Home Demonstration which did not recoup money from practices. Instead, participation was suspended until the practice could show savings.

2. Should CMS limit capitated payment arrangements to ACOs with prior risk-bearing experience – either through participation in a previous Shared Savings Program agreement period in a two-sided risk track (BASIC tracks C, D, E or the ENHANCED

track) or through prior participation in a risk-bearing track in an Innovation Center model, such as ACO REACH – or should risk-bearing ACOs in their first Shared Savings Program agreement period also be eligible to participate in capitated payment arrangements? Why would commenters support one approach over the other? We are interested in whether prior experience with risk-bearing should be an explicit prerequisite for capitated payment eligibility or whether risk-bearing ACOs in their first agreement period should also be eligible to participate in capitated payment arrangements.

As noted above, the additional need for regulation and monitoring is another reason we believe payment through the ACO is not appropriate, regardless of previous experience with bearing risk.

3. Should CMS establish a minimum percentage of attributed beneficiaries for whom eligible primary care practices must be furnishing care management services to receive capitated payments, either at the ACO level or at the individual ACO participant level?

We do not see why that would be necessary. ACOs have inherent incentives to provide care management. If additional support for primary care is furnished through capitated payments, it should be available to individual participants.

4. To what extent should the payment design and structure differ based on the level of risk or participation track of an ACO?

Consistent with our recommendations/comments above, there is no need to have variation based on risk level.

c. <u>Payment Design and Structure</u>

1. What percentage of base year OM payments should be replaced by PCC, and what factors should guide this determination? For example, under the ACO REACH model, the PCC payment – including both the base PCC and the enhanced PCC - is set at 7 percent of the REACH ACO's prospective monthly performance year benchmark, a level designed to provide ACOs with a predictable, non-visit-based revenue stream for primary care services.

We believe any primary care capitation, including APCM, should bring primary care spending towards 7% of the national attributable beneficiary rate. As noted above, complex benchmarks and savings adjustments may not fully mitigate reductions in the capitation amount that may occur as savings increase unless primary care is rewarded for past success. It cannot be a race to the bottom. Additionally, individual practices or professionals should get recognition for caring for patients of greater complexity. Internal redistribution of funds based on risk-adjusted primary care resource use may be necessary within an ACO or even a group. If payment is made to the ACO, CMS should require that a certain percentage must go to the practitioner and that the ACO establish a risk adjusted method for distribution. This seems unnecessarily complex. CMS could negate this need by paying the risk-adjusted capitation amount directly to the practice. The risk adjustor should be based upon the resource costs of high-quality team-based advanced primary care.

2. What services should be included in primary care capitation (and reciprocally, in a fee reduction) to accurately capture an appropriate scope of primary care services furnished to beneficiaries, balancing the importance of providing up-front flexible payments, with the potential for risk to practices if service utilization grows? For example, under both the ACO REACH and ACO PC Flex models, the set of services eligible for primary care capitated payments is based on a specific list of CPT and HCPCS codes billed by primary care specialists (health care providers with specific specialty codes). In both models, the PCC bundle includes certain E/M office visits along with CCM, behavioral health integration, transitional care management, AWVs, advance care planning, and virtual communication services.

The current list of services under REACH and FLEX is reasonable. Separate payment may incentivize certain services (e.g., AWV). While some practices specialize in home or inpatient care (hospital or skilled nursing facility (SNF)), we would not include these services in the capitation unless there is a specific capitation designed for clinicians that focus on home or nursing facility care, such as under Independence at Home. Rural clinicians should receive enhanced payments. Behavioral health services should not be included in the typical capitation amount or should result in an additional capitation payment level if furnished in an integrated behavioral health primary care practice.

The most important consideration is to appropriately adjust the cap as other payments change. For example, the introduction of the APCM should have immediately led to an increase in capitation amounts. Capitation is only useful when it is adequately funded to support advanced team-based primary care. When properly funded, it creates the flexibility to more efficiently care for different populations, which is essential in view of the worsening shortage of primary care clinicians nation-wide.

By asking which services should have a fee "reduction" as compared to being completely bundled, CMS seems to be asking about a hybrid model as was used in Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF). Hybrid models are very reasonable, but the included code list is the same for fully capitated primary care or hybrid payment care. The same code could be paid in full via capitation or paid partially in a monthly capitation and partially as a proportion of the FFS rate as was done in CPC+ or with a flat visit fee as was the case in PCF. Due to beneficiary cost sharing, all models are inherently hybrid unless for preventive services which have no cost sharing. This is because in all models to date, standard beneficiary cost share rules were applied to encounters reported with a CPT or HCPCS II code.

3. We are interested in feedback about whether and in what form we should establish an enhanced primary care payment amount – in addition to the base primary care capitated payment amount – as a feature of primary care capitated payment arrangements in the Shared Savings Program. Specifically, we are interested in:

   ++ Calculation: For example, in ACO REACH, the enhanced primary care payment is calculated as a fixed percentage of the ACO's performance year benchmark, while in ACO PC Flex, the Flex Enhancement component of the primary care payment is calculated as a fixed dollar amount ($125) per eligible beneficiary per year, with

additional enhancements (i.e. the County Enhancement) derived from county-level or regional spending benchmarks.

++ Reconciliation: In ACO REACH, enhanced primary care capitation (EPCC) is subject to recoupment at the end of the performance year. In ACO PC Flex the enhanced amount is included in total cost of care, subject to offsets from the prior savings adjustment and/or the regional adjustment.

It is reasonable to include any capitation in expenses and benchmarking for the ACO. Since savings calculations and even some quality metrics cannot be measured with validity at the clinician level, an ACO participant could get a percentage increase (or possibly deduction) based on performance of the ACO as a whole, similar to the design of the PCF model. A recoupment vehicle for losses need not be directly made in a manner affecting primary care infrastructure supports as long as the ACO as a whole has the ability to cover shared loss. An ACO may recognize the need to increase primary care investment after a loss, not to reduce support.

4. We are interested in whether CMS should consider offering an advanced payment option (APO) within the Shared Savings Program, similar to the APO offered by the ACO REACH model, to ACOs that have elected PCC. Specifically, we are interested in:

   ++ Does the availability of an APO enhance an ACO's ability to align specialist financial incentives with the ACO's total cost of care goals, or do the structural and administrative requirements of implementing an APO within the Shared Savings Program present barriers that outweigh the potential benefits?

   ++ Do Shared Savings Program ACOs have access to sufficient data – shadow bundles, claims data, public use files, and data from arrangements with other payers – to support the development and ongoing administration of an APO? If not, what data would be necessary?

Small ACOs may need advance payments to build infrastructure and create incentives. Larger ones do not need advance payments as those payments will eventually be recovered (albeit 8-20 months later). In general, specialty capitation or specialty incentives are complex to implement and, in most cases, may prove to be of greater burden than benefit. Shadow bundles may be helpful but are not necessarily sufficient. Episode payments have many variables and assumptions built in. Moreover, in some instances, the most cost-effective episode would result in a bundle not being initiated because less intervention may be clinically better. For example, knee osteoarthritis care and Comprehensive Joint Replacement (CJR) bundles that reflect quality and efficiency when surgery is performed but not when non-surgical care is provided. CMS should allow the ACO to receive and distribute specialty funds as capitation and eliminate FFS billing for ACO members, if the ACO so chooses and the specialist are willing. This may be challenging with provisional prospective attribution which is not finalized until the end of the year. Specialty engagement is a national challenge and this RFI may bring forth ideas that have been successful.

5. The ACO REACH model has offered TCC as a payment option for ACOs assuming the highest level of financial risk. The LEAD model also plans to offer TCC as a payment

option for ACOs assuming the highest level of financial risk. We are interested in whether CMS should provide a full capitation option to Shared Savings Programs ACOs. Specifically, we seek feedback on:

++ Should CMS consider offering a full capitation option to Shared Savings Program ACOs that have demonstrated readiness to administer prospective payments, under which all Medicare Part A and Part B services furnished to assigned beneficiaries by ACO providers/suppliers billing through the TIN of ACO participants – but not services furnished to assigned beneficiaries by providers that are not on the ACO's participant list – would be paid through a TCC payment?

++ Should CMS limit full capitation to ACOs in tracks with the highest level of risk – ENHANCED track or BASIC track Level E – on the basis that full capitation should be reserved for ACOs that have already assumed downside financial risk and the organizational readiness to manage prospective payment for Medicare Part A and Part B services?

++ Are there other flexibilities that CMS should give ACOs to make TCC effective?

++ How should CMS calculate the per-beneficiary, per-month payment amount under a full capitation arrangement in the Shared Savings Program? Under ACO REACH, the monthly TCC payment amount paid to the ACO equals 1/12 of the performance year benchmark, adjusted by the TCC withhold.

We do not favor total cost of care (without shared risk) or Direct ACO models, which are essentially Medicare Advantage plans without all the required protections or capabilities of Medicare Advantage. The insurance risk is too great under those models. If an ACO becomes insolvent, it adversely affects the ability of the provider community to serve non attributed beneficiaries, patients with commercial/exchange insurance, Medicaid beneficiaries and others. While the causes are different, one simply needs to look at the impact of private equity hospital system bankruptcy to see how a community can be adversely affected.

6. Should CMS issue prospective capitated payments on a monthly or quarterly basis? Please describe the potential advantages, disadvantages, and operational implications of each approach.

We do not have a recommendation regarding the distribution schedule. Adjustments will occur either way, although cash flow for operations may be enhanced by monthly payments.

7. Should capitated payments be paid to ACOs and distributed downstream to ACO participants, or should CMS make payments directly to ACO participants that provide primary care services, similar to how CMS makes payments for APCM services, and what are the implications of each approach? Should CMS consider alternative mechanisms for delivering capitated payments directly to ACO Participants that are also primary care practices participating in Shared Savings Program ACOs? If so, what payment design, infrastructure, and policy

considerations should guide the development of such alternative payment mechanisms?

Any capitated payments should be made directly to the ACO participants, similar to the manner in which CMS currently makes payment for APCM services. We have provided additional rationale above.

8. If capitated payments are issued directly to ACOs, should CMS require ACOs to provide a specific percentage of those payments to ACO participants that provide primary care services? How might this be audited? Additionally, should CMS require ACOs to have written capitated payment agreements with ACO participants to specify that a minimum percentage of the capitated payment will flow to ACO participants?

CMS should pay any capitated amount directly to the ACO participant or at least require a minimum amount to be immediately paid to the participants, if payments are made to the ACO. We have not done a detailed analysis, but we estimate that at least 70% of the projected payment amounts should go to the participants to cover basic operations to provide E/M.

d. <u>Care Delivery Requirements</u>

1. Should CMS require ACOs seeking to participate in capitated payment arrangements to make commitments to specific care delivery goals as a condition for participation? If so, what goals should be required and how should compliance be assessed and enforced? For example, we are interested in whether we should require ACOs to submit a primary care transformation plan – similar to the care delivery requirements under the CPC+ model, which required participating practices to demonstrate progress across five comprehensive primary care functions, including access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health – that specifies measurable targets for care delivery improvements, such as expanding after-hours access, increasing care management for high-risk beneficiaries, or reducing avoidable emergency department utilization.

Most of the stated goals are inherent to being a successful ACO. Increasing administrative or regulatory burden by requiring specific commitments could dilute primary care support and divert resources from improving patient care. If CMS were to direct all primary care payments to the ACO, then some aspect of these requirements may be necessary. ACOs already have quality metrics which are set nationally and are not ACO specific. If the national metrics need to be improved, CMS should do so through the rulemaking processes. While all the functions listed above are useful, actionable, valid metrics regarding them are less clear. For example, metrics related to "avoidable emergency department utilization" requires that such utilization be defined, may not truly measure what is avoidable, and are usually based on criteria that are ultimately related to community resources, not the ACO alone. Such metrics are typically not adjusted for social risks such as transportation access and therefore may inappropriately penalize ACOs in rural or underserved areas.

2. How should CMS balance meaningful capitated payment levels with reduced administrative and reporting burdens for participating ACOs, and what primary care delivery requirements should CMS establish as conditions of eligibility for capitated payment arrangements in the Shared Savings Program? Should compliance with any care delivery requirements be monitored on a quarterly or annual basis, with the potential for payment recoupment in cases of noncompliance?

CMS should still require claims to be filed for capitated primary care services, in order to facilitate cost sharing and data collection. CMS should ensure that the cost-sharing structure does not disincentivize performance of important services such as the AWV. An advantage of capitation for all primary care services is that care management fees are blended with other services and do not have a specific cost-sharing portion. This removes one of the major barriers to the use of APCM today. We do not recommend billing care management monthly but rather suggest that capitation be paid automatically for attributed beneficiaries as was done in CPC+ and PCF. CMS should absolutely not use the flawed "leakage" methodology used in the PCF model, where all advance practice clinicians were considered primary care which resulted in primary care practitioners effectively paying for specialty care performed by APRNs via penalties. The penalties also reduced care management payments, which should be greater when additional care coordination is required for that specialty care. Even out of area care was penalized when clearly the continuity primary care practitioner did more work to coordinate care when a person needed care while on vacation or as a snowbird. AGS has commented annually that CMS needs to adopt a taxonomy system that differentiates advanced practice clinicians by practice type and not make assumptions based on licensure category or certification. We also communicated verbally with the National Uniform Claim Committee (NUCC) staff on this matter. Private payers properly attribute beneficiaries by differentiating advanced practice clinicians as engaged in primary care, specialty care or behavioral health. Appropriate provision of primary care services, including care management and transition management, are inherently rewarded by the Shared Savings structure and the ACO has incentives to furnish those services without the need for a reporting and audit system. Additional administrative burden is not warranted, CMS has considerable experience with ACOs and if there are significant program deficiencies that require resolution, they should be specified for better analysis and comment.

3. Should CMS require that ACOs and ACO participants receiving capitated payments demonstrate the use of data-driven risk stratification methods to identify high-risk beneficiaries and target enhanced care management resources toward those beneficiaries? CMS provides Shared Savings Program ACOs with data that could be used for risk stratification, such as claims-based beneficiary data, risk scores, and quality performance reports. We are interested in whether CMS should require ACOs and ACO participants to use these data as a baseline input for their risk stratification methodologies or whether ACOs and ACO participants should be given the flexibility to design their own risk stratification approaches.

CMS should allow ACOS and ACO participants the flexibility to design their own risk stratification approaches. ACOs have more innovative and real-time methodologies and should be able to adapt

as new approaches are developed or experience suggests current approaches need refinement. CMS data is useful because not every event is known to the ACO but generally it is dated by the time it becomes available. CMS data is most useful not in patient care but in monitoring ACO performance relative to other ACOs, where it may help ACOs identify areas where additional changes or effort is needed.

4. Should care delivery requirements for capitated payment eligibility increase depending on the level/type of capitated payment selected by the ACO or ACO participants? For example, should ACOs that are receiving a higher percentage of capitated payments be subject to more comprehensive care delivery requirements or should a uniform set of care delivery requirements apply to all ACOs, regardless of the percentage of capitated payments they receive?

AGS does not recommend care delivery requirements for any level of capitated payment.

e. **Primary Care Capitated Payment Arrangements Considerations outside of the Shared Savings Program**

1. What would be the appropriate services to bundle in such a primary care global period (e.g. E/M, care management codes, AWV, etc.)? How should the agency consider the benefits and drawbacks regarding quality of care, patient safety, and evidence regarding care delivery changes in a fully or globally capitated approach with no per-visit payment vs. a hybrid payment approach with reduced per-visit payment and per-member per-month payment?

The same principles apply whether or not a primary care practitioner is or is not in an ACO, though concerns about potential reductions in service are greater outside of an ACO. Primary care capitation (often called "subcap") may be acceptable, but it should not include all types of E/M visits. For example, most primary care practitioners do not perform hospital, nursing facility care or home visits. Those that do should receive additional payment. PCP payments should not be related to total cost of care. AGS favors a hybrid approach; full capitation should only be implemented with appropriate monitoring, required reporting of services and quality, and most importantly adequate risk adjustment. We believe inclusion of care management in capitation can alleviate the burden of monthly APCM billing and cost sharing as commented above.

2. For both a fully capitated and hybrid payment approach, CMS has in past considered patient complexity (e.g. number of chronic conditions or HCC level) in our alternative payment models for primary care. How should CMS approach defining these levels or stratum for payments in a fully capitated or hybrid payment model for primary care? How many levels should be considered?

CMS should stratify payments based on utilization of resources related to primary care delivery. The CPC+ model used a good methodology that appropriately strengthened primary care. We believe the adjustment for complexity should occur at the patient level like CPC+ and not at the practice level like PCF. Within any practice, the group should be able to reward clinicians who accept responsibility for more complex patients, which CPC+ made simple. Other methods require redistribution of payments based on risk scores, which may be lagged. Analytics may help define

the appropriate number of levels, but we believe it should be more than the three tiers used in APCM. The levels should include some diagnosis criteria even though that may create some additional burden and gaming potential. The amount of resources required to treat two or more conditions can differ significantly depending on what those two conditions are - for example, heart failure and dementia compared to stable hypertension and hyperlipidemia. We acknowledge that averaging over a larger population makes this issue less relevant. However, AGS members do not care for the average blend of beneficiaries and therefore an appropriate adjustment is needed for clinicians treating the most complex, high needs patient populations. We suggest a higher level for people that are homebound and incorporating functional status if feasible. Rural practices may also need enhanced payment regardless of patient medical condition(s) as they inherently must provide a greater scope of services.

3. In the absence of an encounter, is there another appropriate 'trigger' or initiation for a primary care global period? How long should it last? Is beneficiary receipt of an AWV in the previous 12 months sufficient?

Under any model, there will be attributed and non-attributed beneficiaries. Once a beneficiary is attributed to a primary care practice, the monthly capitation payment should begin. Payments can be distributed quarterly but monthly amounts or adjustments better allow for attribution changes due to various reasons including death. AWVs remain the best attribution event, as long as AWVs are not allowed to be furnished by practitioners without a continuity relationship. Such approach promotes use of the AWV in order to gain attribution and the additional resources and flexibilities associated with the primary care capitation. The look back for attribution should be longer than 12 months because AVW's can only be furnished once in a 365-day period. In a well-run primary care practice, the AWV will have been furnished in the prior 13 months, and a 12 month look back may not properly identify patients who should be attributed to the practice. Attribution should be by the most recent AWV in the last 18-24 months or, absent an AWV, the preponderance of office/outpatient E/M by a primary care clinician (properly defined for advanced practice clinicians). Voluntary beneficiary designations are reasonable as well and the process of making the designation should be simple and able to be performed both electronically and on paper.

4. What necessary reporting requirements and accountability should CMS require for clinicians receiving primary care capitated payments? For example, should there be explicit minimum visit requirements for a clinician to be eligible to receive primary care capitated payments for their Original Medicare patients? Should we require specific clinical outcomes based reporting? If so, what clinical outcomes should we measure?

There should be no minimum number of required services. Capitation is inherently built upon spreading payments over a population, some of whom need few services and others who need many services. The attribution methodology will eliminate patients who receive no services from triggering primary care capitation. Complexity adjusted payments also promote proper payment amounts. Any outcomes measures must be reasonable based on the level of measurement and population size. For example, risk adjusted admits per 1000 may be a good statistic for an ACO with 5000 beneficiaries, but the volatility and invalidity of such a measure in a small population is

plain. The number of measures should be limited. Practices should not have to sustain additional costs of member satisfaction surveys to receive capitation, though CMS could elect to perform such surveys for all ACO patients. Ideally any measures used for capitation outcomes assessment/compliance are already part of MIPS MVP or the ACO quality measurement program.

5. Broadly, to what extent should the approach Original Medicare takes to primary care payment differ between the Shared Savings Program and the broader program? If yes, how?

There should be limited, if any, differences between primary care payment within the Shared Savings Program and the broader Medicare program. We acknowledge the integrity protection inherent in an ACO but believe that any risks for the broader program can be effectively mitigated. It is reasonable for CMS to wish to stimulate ACO participation and to recognize the inherent added care coordination and complexity of ACO participation. The proposal to modify G2211 helps to achieve that goal. ACOs should have the ability to include participants that have elected primary care capitation and those who have not. This worked well historically by allowing CPC+ and PCF participants into MSSP ACOs. This is possible structurally, because we do not suggest that CMS use total cost of care capitation at the participant level.

6. In so much as the agency considers a prospective primary care payment (PPCP) for primary care, to what extent should the IPPE/AWV be the initiating visit for that global period?

Use of IPPE/AWV for attribution is reasonable if only continuity practitioners are allowed to furnish these services. The IPPE/AWV should not be a required initiating visit for PPCP. The IPPE/AWV should be furnished by a practitioner with an ongoing relationship with the patient and who serves as the continuing focal point for all of the patient's needed health care services. However, provision of the IPPE/AWV by itself does not establish that relationship. Use of the IPPE/AWV as the initiating visit that triggers PPCP would incentivize provision of that service but would not necessarily support the practice that is actually furnishing the patient's primary care. In addition, the AWV can only be furnished once in a 365-day period, and patients would be locked into a specific practice for a 12-month period, regardless of where they are receiving care. For all practices, some number of patients will be misattributed because the patient has left but not yet had another AWV to trigger a new assignment. This model would be particularly problematic for home-based practices whose patients would likely be attributed to a brick-and-mortar practice that was caring for them prior to the patient becoming homebound. Reliance solely on the AWV would also mean a substantial number of beneficiaries will not be attributed at all. Promoting the AWV is good but making it mandatory for a better payment system is not.

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The AGS greatly appreciates CMS' interest in strengthening primary care and we would like to continue to partner with CMS to achieve that shared goal. We urge the agency to ensure that any reforms reinforce patient-clinician relationships, reduce administrative burden, and provide adequate resources directly to primary care practices. AGS supports existing approaches such as G2211 and the Advanced Primary Care Management (APCM) codes and cautions against adding

unnecessary new coding structures. While AI and other technologies may improve documentation, data collection, risk stratification, and care management, AGS believes the evidence on their impact on outcomes and costs remains limited and recommends that CMS avoid prematurely incentivizing specific technologies or allowing them to substitute for clinician judgment and continuity of care. AGS similarly supports AWVs as an important component of whole-person, relationship-based care and opposes AWV services primarily designed to increase coding intensity. For prospective or capitated primary care payment, AGS favors carefully designed, risk-adjusted approaches—generally including a hybrid payment model—with payments made directly to primary care practices rather than routed through ACOs. Overall, AGS recommends that CMS judge primary care innovations by whether they strengthen continuity and capacity, appropriately account for patient complexity, minimize administrative burden, and improve outcomes that matter to beneficiaries, including whether care is consistent with the beneficiary's individual goals and priorities.

We appreciate the opportunity to provide the above comments and recommendations and would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,

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