AGS | THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading change. Improving care for older adults.

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Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (CMS-3321-NC)

Dear Mr. Slavitt:

The American Geriatrics Society ("AGS") appreciates the opportunity to comment on the Request for Information ("RFI") Regarding Implementation of the Merit-Based Incentive Payment System ("MIPS"), Promotion of Alternative Payment Models ("APMs"), and Incentive Payments for Participation in Eligible APMs (CMS-3321-NC).

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. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our vision for the future is that every older American will receive high quality patient-centered care. In order to achieve this vision, we strive to help guide the development of public policies that support improved health and healthcare for seniors. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the Medicare physician fee schedule ("PFS").

Our general, over-arching comments on the RFI focus on the following:

MIPS Should Support Transformation. The implementation of MIPS offers many opportunities to advance meaningful transformation to value-based payment systems that meet the healthcare needs of older adults. Understanding that the new payment system created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) gives eligible professionals (EPs) strong incentives to join APMs, nonetheless the availability of APMs will vary geographically and by specialty. CMS' policies with regard to the MIPS should support this transformation for EPs who lack access to APMs and include the following essential elements:

- High quality, patient-centered care that takes into account differences in the complexity of older patients' healthcare needs;

- Quality and risk adjustment measures that address Medicare beneficiaries who have multiple chronic conditions, advanced disease, are frail, or have cognitive and physical functional limitations; and

- Payments and other incentives that value and strengthen primary care and care coordination, and provide support to interdisciplinary geriatrics care teams for complex and/or high cost patients.

In other words, the MIPS should transcend distinctions between "fee-for-service" and "pay-for-performance" and instead support transformation to a value-based healthcare system that takes into account the whole patient and the whole patient experience.

Geriatricians Need Measures for Complex Patients, Not Single Diseases. While we truly appreciate CMS' efforts to increase the number of quality measures that are available for reporting, we continue to believe that the current Physician Quality Reporting System (PQRS) measures are insufficient for geriatricians and their unique patient population. The need for appropriate measures for geriatricians grows increasingly urgent given the prospect of MIPS downward adjustments to payments.

AGS Supports CMS' Efforts to Establish Payment for Coordinated Care and Advance Care Planning. AGS strongly supports CMS' decision in the 2016 Final Rule for the Medicare Physician Fee Schedule to pay for Advance Care Planning services at the amounts recommended by the RUC. AGS also supports CMS' prior decision to pay for chronic care management (CCM) and transitional care management (TCM) services. We believe that payment for those services will, over time, foster better understanding of the roles geriatricians can play in the healthcare provider team, and bolster the case for the inclusion of geriatric care in (1) training programs for medical students and residents, and (2) continuing medical education for specialist physicians.

AGS thanks CMS for finalizing the proposal to add several new cross-cutting measures. AGS believes that the new measures of Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling; Falls: Risk Assessment; and Falls: Plan of Care will be more relevant than the many specialty-specific measures and even the existing cross-cutting measures for geriatricians who treat complex patients who are -- because of their multi-morbidities -- receiving care across provider specialties. Finally, AGS thanks CMS for finalizing the proposal to establish a new measures group for Multiple Chronic Conditions.

Our comments on specific sections of the RFI include the following:

A. The Merit-Based Incentive Payment System (MIPS)

1. MIPS EP Identifier and Exclusions

As a general rule, all physicians and NPPs who receive Medicare payment are eligible to participate in the MIPS. The AGS endorses the recommendations of the American Medical Association (AMA) with respect to the EP identifier and exclusions. In particular, AGS believes that CMS should establish a simple and flexible process for identifying MIPS EP's. Creating a new MIPS identifier would be burdensome and risks losing EPs who are already participating in PQRS but do not know they need to re-enroll. AGS also

believes that CMS should consider the freedom of an individual EP to participate (or not) when the quality measures of a large practice group are submitted on their behalf through the GPRO interface. EPs who may have more appropriate quality measures for their specialty through other reporting mechanisms should be able to use them, particularly given that CMS plans to compare EPs' performance stratified by reporting mechanism.

AGS also believes that all MIPS eligible professionals (EPs), both primary care practitioners and specialists, who treat Medicare beneficiaries should be able to demonstrate basic competency in geriatric care given the demographics of the Medicare population. AGS would be pleased to collaborate with CMS to identify educational opportunities that could help meet this goal, while potentially also meeting requirements for clinical practice improvement activities.

AGS further recommends that CMS partner with specialty societies to build on collaborative initiatives that have existed for many years and have important knowledge and perspectives. Since 1994, the AGS Geriatrics-for-Specialists Initiative (GSI) has conducted collaborative activities with numerous organizations and leaders in academic medicine, all designed to increase awareness of and knowledge in the care of older adults among surgical and related medical specialists. The goals of the initiative include enhancing the geriatrics knowledge and expertise of practicing surgeons and medical specialists through continuing medical education, maintenance of certification programs, and quality measures that help to improve the care that they provide to frail older adults. GSI also works to improve the amount and quality of geriatrics education received by specialist trainees.

Over many years, the AGS, working through the GSI, has established an independent, sustainable collaboration with several other specialty societies, including the American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology – Head & Neck Surgery, American Academy of Physical Medicine and Rehabilitation, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Surgeons, American Society of Anesthesiologists, American Urological Association, Society for Academic Emergency Medicine, Society of Thoracic Surgeons, and Society for Vascular Surgery. The member societies, and their respective training and certification programs, work together to carry out the GSI's mission and goals.

The GSI has published a statement of principles[1], and competencies in geriatric patient care for use in initial and continued board certification of surgical specialists. The competencies cover domains of (1) atypical presentation of disease, (2) medication management, (3) cognitive and behavioral disorders, (4) complex / chronic illness, (5) informed consent / refusal, (6) transitions of care, (7) patient safety, and (8) advanced directives / palliative care / end of life.[2] We would be pleased to meet with CMS to discuss further how to ensure that all EPs in the MIPS program have basic competency in the care of older patients.

[1] "A Statement of Principles: Toward Improved Care of Older Patients in Surgical and Medical Specialties." Journal of the American Geriatrics Society 48:699-701, 2000. Available at http://www.americangeriatrics.org/files/documents/gsi/statement.pdf

[2] Richard H Bell Jr, MD, FACS, George W Drach, MD, FACS, Ronnie A Rosenthal, MD, FACS. "Proposed Competencies in Geriatric Patient Care for Use in Assessment for Initial and Continued Board Certification of Surgical Specialists." Journal of the American College of Surgeons, 213 (5): 2011. Available at: http://www.americangeriatrics.org/files/documents/JACS.Competencies.pdf

3. Quality Performance Category

a. Reporting Mechanisms Available for Quality Performance Category

AGS endorses the many recommendations of the AMA with respect to current PQRS reporting measures and criteria, particularly that CMS should fix things that are not working and remove the inflexible requirement for 9 measures in 3 national quality strategy domains. AGS also agrees with the AMA that EPs should be able to report measures via multiple reporting mechanisms to maximize their ability to report measures that are meaningful for their practice.

AGS recommends that CMS use the new authority in MIPS to create a low-volume threshold to exempt from payment penalties those EP's who are unable to report PQRS data because of their individual practice setting.

AGS recommends that CMS consider factors such as the EP's specialty (e.g. pediatrics), geographic location (e.g. rural county), volume of Medicare patients in the year, and Medicare billing (e.g. less than a *de minimus* amount) as criteria for such an exclusion.

In the absence of such an exclusion, AGS recommends that CMS follow the approach outlined in the AMA's comments, especially 1) the need to address issues of attribution and risk adjustment in measuring outcomes, 2) allowing for other types of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and refining the "experience of care" measures, 3) using the flexibility in MACRA to adjust the weights of the performance categories for EPs who have difficulty meeting requirements for meaningful use, and 4) allocating funding from MACRA to the development of measures that will fill the significant gaps that persist for medical societies and specialties that have not been able to develop measures on their own due to lack of resources.

b. Data Accuracy

AGS understands CMS' concerns about the quality of the data reported for the PQRS. Given that EHR technology must meet federal standards and qualified clinical data registries (QCDRs) must be approved by CMS for use in data reporting, AGS believes CMS should establish standards for data quality. AGS endorses the AMA recommendations regarding a process for validating data submissions, providing feedback when submissions fail, and placing vendors on corrective action plans. The information technology industry will follow standards if CMS establishes and enforces them. Physicians are not well equipped to establish such standards but will be penalized for not submitting data in a format that CMS can use, and thus should be held harmless when errors are made by vendors or CMS that affect EPs' performance scores. Physician societies have made substantial investments in registries and need assurance that their members can benefit from using them.

4. Resource Use Performance Category

AGS notes that the RFI does not ask for recommendations about changes to the Value Modifier (VM) program, and agrees with the AMA that CMS should devote significant data analysis and resources to replace, not expand, the current VM cost measures. In its current construct, the VM penalizes EPs repeatedly for the same high-cost patients with multiple chronic conditions. Congress recognized these flaws and envisioned changes to the program.

AGS endorses the AMA's recommendations to improve current quality and reporting systems so that each of the individual MIPS categories includes measures that are valid, reliable, relevant, and actionable. Medicare's existing reporting and quality measurement programs cannot simply be combined to create the new MIPS program. These currently separate programs must be carefully assessed, revised, aligned, and streamlined into a coherent and flexible system that is truly relevant to high-value care. AGS commends CMS for creating new codes for CCM, TCM, and Advance Care Planning. We believe that uptake of these codes should be measured. For example, CMS could determine whether a CCM service was billed within 30 days of a hospital discharge. By measuring processes of care AND paying directly for collaborative care and chronic care management, the resource use component of the MIPS can drive high-value care.

In the RFI, CMS asks whether to create new measures of potentially over-utilized services, such as those identified in the Choosing Wisely initiative. AGS supports the Choosing Wisely initiative of the American Board of Internal Medicine (ABIM) Foundation and has submitted ten recommendations, which address issues such as use of restraints, medications, screening tests and feeding tubes.

AGS agrees that CMS could use the Choosing Wisely recommendations, which represent the consensus views of experts in many medical specialties, together with Medicare claims data, to establish some utilization measures. AGS cautions that if Choosing Wisely recommendations are used, they should measure achievable gaps in quality of care for which it is possible to measure individual EP performance in a statistically valid way with claims data. Such measures, if used, should not burden providers with additional data entry for information CMS already has.

The RFI also asks about the extent to which outcomes should be measured and weighted. While we agree that measures should, in general, not duplicate other measures and measure outcomes rather than processes of care, AGS believes that the limited set of outcome measures available currently do not address concerns about risk adjustment and attribution. CMS should include criteria, such as site of service adjustments for EPs practicing in hospitals and nursing homes, that would assess these issues and guide decisions about how quickly to eliminate measures that may be best suited for reporting by a small group of EP's.

For CY 2018, CMS is continuing its policy that if an Accountable Care Organization (ACO) does not successfully report quality data as required by the Shared Savings Program, all groups and solo EPs participating in the ACO will fall in Category 2 for the VM, and will be subject to a downward adjustment. CMS should use its discretion to create a hold harmless provision for EPs who have agreed to participate in an ACO whose data is not reported through no fault of their own.

5. Clinical Practice Improvement Activities Performance Category

AGS endorses the AMA's comments on clinical practice improvement activities, including that patient satisfaction surveys should be measured within this category and not within the quality category. CMS should be broadly inclusive of activities in which EPs are already engaged, particularly those that are mandated by Medicare or other federal or state government programs -- such as participation in registries, the Million Hearts Campaign, or state Quality Improvement Organization (QIO) activities. AGS agrees with the AMA recommendations to count ongoing participation in these activities, rather than a specific number of hours, and that the activities should be equally weighted initially.

By law, clinical practice improvement activities must include the subcategories of expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an APM. AGS endorses the activities recommended by the AMA that fulfill these requirements, including remote monitoring of chronic conditions, billing CCM and TCM codes, and nutritional counseling. AGS believes that CMS must limit administrative burdens and streamline reporting tasks so that the delivery of patient-centered care is the principal focus in all clinical settings. Small and rural practices should have options for participation that are free or low cost.

AGS recommends that CMS use the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) Part IV, Improvement in Medical Practice, as one option for clinical practice improvement activities in the MIPS. The ABMS MOC requires that, to maintain board certification, EPs engage in ongoing assessment and improvement activities to improve patient outcomes, and demonstrate use of evidence and best practices compared to peers and national benchmarks.[3]

CMS should strive for seamless integration between the ABMS member Boards and the MIPS so that EPs who have completed the required number of credit hours for their specialty board are deemed to have met the CMS requirement for clinical practice improvement activities, and do not have to submit the same information on their activities and the credits earned to CMS.

MACRA requires that participation in a Patient Centered Medical Home (PCMH) receive the maximum score for clinical practice improvement activities. AGS recommends that CMS extend this concept so that EPs who are performing those activities in an accredited PCMH program receive credit for participation in an APM, regardless of whether the program is sponsored by CMS or by a private or state entity if the PCMH program is not participating in a CMS PCMH program.

In the MACRA RFI CMS asks for recommendations on activities that could be clinical practice improvement activities that contribute to policy goals such as Promoting Health Equity and Continuity and Social and Community Involvement. AGS believes that CMS can incentivize these activities by continuing to pay directly for CPT codes for CCM and TCM, and by, in the future, paying directly for new Evaluation and Management codes for collaborative care, currently in development within the CPT process.

CMS could use claims data to determine the extent to which EPs are using certain codes (e.g. CCM and TCM) for episodes of care where they are medically indicated. With respect to activities in the area of Social and Community Involvement, such as measuring completed referrals to community and social services, AGS believes that CMS should adopt measures of the success of referrals of patients within regional collaboratives or other networks. For example, CMS could create measures that link hospitals' performance in preventing readmissions with the performance of community-based EPs who participate in an ACO that includes the hospital within the context of a regional collaborative.

AGS believes that emergency preparedness activities, such as participation in the military reserve corps or voluntary humanitarian medical relief work, are not appropriate measures of clinical practice improvement activities.

As a general rule, AGS believes that geriatricians will have many clinical practice improvement activities for the categories, defined in MACRA, of expanded practice access, population management, care

[3] More information is at http://www.abms.org/board-certification/a-trusted-credential/assessed-through-a-four-part-framework/

coordination, beneficiary engagement, and patient safety. AGS looks forward to working with CMS to identify those activities with greater specificity.

6. Meaningful Use of Certified EHR Technology Performance Category

The RFI requests comments on the extent to which Certified EHR Technology (CEHRT) should be required for quality measure reporting and whether the Meaningful Use component of the MIPS, which is worth 25 percent of the total composite score, should be an "all or nothing" measure. CMS seeks comment on development of a tiered methodology that could be an alternative to "all or nothing," and whether the thresholds used for performance comparisons should be based on those in the EHR Incentive Program or relative to a peer group. AGS endorses the recommendations of the AMA with respect to ensuring that Meaningful Use is achievable for all EPs.

Further, AGS endorses the AMA recommendation that Stage 3 objectives should score in an accumulative fashion toward the 25 percent score for the category rather than having an all-or-nothing approach in the MIPS. Many factors contribute to an EP's ability to meet Meaningful Use objectives, including the EHR capabilities of the facilities where they practice, the functionality built into the EHRs by EHR vendors, and patients' behavior. AGS endorses the AMA recommendation that CMS should be flexible in the types of hardship exemptions that are available for EPs, and should re-weigh the performance categories for EPs who are unable to demonstrate Meaningful Use and receive a hardship exemption so they are not immediately penalized for having done so.

MACRA requires CMS to establish new codes that describe physician-patient relationships, for the purpose of focusing resource use measures on aspects of the care pathway that are within the scope of control of an individual EP. AGS believes that a similar concept is needed to focus the meaningful use measures on those activities that are within the control of the EP, and that partial credit should be given to determine this component of the MIPS composite score. AGS agrees with the AMA that providers should not be penalized for actions they cannot control.

8. Development of Performance Standards

CMS seeks comments on how to select quality and cost benchmarks, particularly for the first two years of the MIPS, the extent to which those benchmarks should be based on existing PQRS data, how to establish a baseline for measures that did not exist prior to MACRA, and whether the benchmarks should vary by group size or other criteria. We note that CMS in the 2016 Final Rule finalized the proposal to create measure-level benchmarks using the Achievable Benchmark of Care (ABC™) methodology. AGS remains concerned that the ABC™ benchmark has never been used for public reporting of physicians' quality of care in a program with the breadth and scope of Medicare. AGS recommends, as in our comments on the 2016 Proposed Rule, that CMS grant a one year period in which ABC™ benchmark data is collected and shared with providers, but not publicly reported. This process would enable CMS to use real-world data to understand the reliability of the data, the size of the sample of providers for each measure, and the impact of the methodology across specialties, geographies, practice sizes, and so on.

Because the PQRS reporting options depend on what services a physician performs as well as the mechanism(s) they have available to report the data, it is critical for CMS to take this into account

when determining how to calculate the benchmarks and at what level of aggregation to report them on the website. AGS tentatively supports CMS' notion of setting the benchmarks based on the reporting method, as that seems to be the best way to make an apples-to-apples comparison among physicians using the performance data that CMS expects to have in 2019. However, AGS recommends that CMS continue its work on streamlining the quality measures and the reporting process to reduce the administrative burden and permit comparisons among physicians who are truly comparable to each other, and not just among those who reported the data in the same way. AGS agrees with the AMA's recommendations with respect to the need for standards that differ based on practice size, specialty, and other factors.

10. MIPS Composite Performance Score and Performance Threshold

AGS recommends that CMS establish multiple formulae that can be used to construct a composite score. Those formulae should cover the possible combinations of practice arrangements such as 1) EPs who bill through a single tax identification number (TIN) vs. EPs who bill through multiple TINs, 2) EPs who report quality measures as individuals vs. EPs for whom data is reported by an entity such as a group practice, and 3) EPs who spend part of their work week or part of a year in one practice setting and part of the week / year in another practice setting.

CMS should also create a tool that EPs can use to review for themselves the data that will be used to create their composite scores, taking into account the sources of data CMS has from PQRS reporting, claims, and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). EPs should have the ability to calculate the composite score using the various formulae and report their score in the way that best represents their practice. The process for calculating an EP's composite score will be at a level of complexity that rivals choosing a Part D plan based on a beneficiary's prescription drug needs and plans' formularies, or a small business owner choosing a health plan through the Marketplaces. CMS has created tools that assist consumers with these complicated decisions, and should create a similar tool for EPs.

11. Public Reporting

In the RFI CMS asks whether data should be reported so it can be stratified by race, ethnicity and gender, and whether data stratified in this way should be publicly reported (assuming it is statistically valid.) AGS endorses the AMA's recommendation for CMS to "press the reset button" and use the MIPS as an opportunity to correct issues that have been widely cited with respect to the publicly reported data. CMS should establish a new system and collect data using the new system for two years. In the second year, CMS should share feedback confidentially with EPs on their performance in the first year via clear, easy-to-understand reports. When EPs have had a year to improve their performance based on the feedback, they should have the opportunity to review the data that will be publicly reported.

AGS agrees with CMS that the MIPS presents opportunities to measure and reduce health disparities. AGS believes that measures of health equity are difficult to develop but that the MIPS measures of resource use could incorporate these concepts. For example, CMS could use claims data to determine not only whether an EP accepted new patients who are Medicaid beneficiaries, but whether Medicaid beneficiaries actually received services from an EP. CMS could develop benchmarks for patient populations such as whether an EP served a disproportionate share of low-income beneficiaries when

compared to other EPs. AGS recommends that CMS carefully consider how the benchmarks for such measures would be established and the appropriate comparator groups -- by specialty, by geographic region, etc. AGS agrees with the AMA that CMS should refrain from implementing stratification of the data until after the foundational issues are addressed as described above.

12. Feedback Reports

EPs Need More Frequent Feedback on Performance. As we have recommended in previous years, we urge CMS to continue to provide multiple avenues for physician involvement and feedback on quality initiatives, such as national conference calls or town hall meetings, so that physicians and other healthcare professionals can understand and respond to the Agency's thinking as it coordinates plans for improving the quality and efficiency of patient-centered care with its other initiatives. Medicare's current process of changing the measures and reporting rules annually and sharing quality and utilization data twice per year (and that is two years old by the time EPs receive it) is completely inadequate as physicians need to understand what metrics are being used to evaluate them in real time, as well as ongoing, real-time (or much closer to real-time) feedback on performance to improve quality. AGS agrees with the AMA's comments with respect to consulting stakeholders to identify the most useful formats for reports, improving the reports over time as technology changes, disclosing methodologies used to calculate EPs' performance, and making the web-based reports more user-friendly for EPs and, importantly, their practice staff.

B. Alternative Payment Models

1. Information Regarding APMs

The RFI asks for comments on how CMS should implement the APM provisions of MACRA. Those include what data providers should submit to CMS to determine whether their payments from private payers are risk-based and how to define "in excess of a nominal amount." AGS has reviewed the legislative language regarding APM participation and notes that individual EPs will likely have difficulty estimating whether they are likely to be "qualifying APM participants" or not. AGS endorses the recommendations made by the AMA:

- CMS should require APM entities to demonstrate meaningful participation of physicians in the governance of APMs that are not physician-owned. Additionally, AGS believes it is a prudent requirement that such participation include physicians with expertise in geriatrics.
- CMS should allow flexibility for proposed APMs to outline different organizational structures and pathways for revenue flows.
- APM entities should submit to CMS the methods they will use to determine whether Eps participating in the APM have met the requirements for qualifying APMs.
- APMs should have the responsibility of determining how they will allocate revenues among physicians, rather than CMS' having a one-size-fits-all approach.
- Setting up APMs involves substantial start-up costs that should count toward meeting the requirement for financial risk that is "in excess of a nominal amount."

MACRA is clear in its intent to encourage EP's to join APM's. There are substantial benefits to APM participation: 5% annual bonus, ability to share resources for reporting, possibility of earning bonuses for high-quality cost-effective care. In order for physicians to participate in APM's, APM's must exist in their practice area. CMS should commit to ensuring that comparable opportunities and risks exist for EPs participating in APM's in all parts of the United States, not only in high cost areas.

2. Physician-Focused Payment Models.

AGS endorses the recommendations of Altarum's Center for Elder Care and Advanced Illness with regard to working towards fundamental changes needed to create a compassionate, cost-effective and trustworthy health care system for a rapidly rising population of frail older adults who are living with chronic conditions and functional limitations. In this regard, we welcome the opportunity to help develop scalable APMs that focus on the frail elderly Medicare population and are appropriately configured to offer both comprehensive medical care and critically important long term support services.

Existing APMs are not designed to meet the needs of this target population. While frail elders are routinely over-treated from a medical perspective, they also frequently experience difficulties securing reliable and necessary supportive services -- such as home-delivered meals, adapted housing, training and support for family caregivers, well-trained personal aides, and transportation. We are among the physician organizations that are dedicated to serving this population, and once the Payment Model Technical Advisory Committee (PTAC) is established, we look forward to proposing ideas for new APM models that can adequately address these needs.

As a generic criterion of evaluation methodologies, CMS should use process control charts specifically and reduce the strong preference for RCT and difference of difference models. With this method, most useful models should prove to be evaluable, though those APMs for beneficiaries with serious chronic conditions and care near the end of life can only be appropriately evaluated when there are improvements in quality measures.

The shift from rescue and "fix-it" procedural medicine to chronic care is epitomized in the commitment to help persons living with substantial health challenges and disabilities to live as comfortably and meaningfully as possible, which requires person-driven care plans, effective medical care, and an array of supportive services. The latter are usually quite tied to the geographic community, which opens the possibility of monitoring and managing services on a somewhat geographic basis, with responsibility for all (and thus reducing inequities).

As MACRA is implemented, we look forward to further collaborative opportunities and to participating in discussions of how physician-focused models can be efficiently developed and rapidly scaled for the growing and challenging cohort of high-need, high-cost frail elders, across settings and time, often during decline and dying, from the patient's perspective as to preferences and priorities about what matters most to them.

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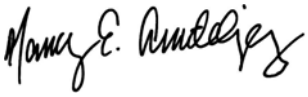
The AGS greatly appreciates the opportunity to comment on this RFI. Please do not hesitate to contact us, agoldstein@americangeriatrics.org, if we can provide any additional information or assistance.

Sincerely,



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