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

THE AMERICAN GERIATRICS SOCIETY
40 FULTON STREET, SUITE 809
NEW YORK, NEW YORK 10038
212.308.1414 TEL
www.americangeriatrics.org

SUBMITTED ELECTRONICALLY VIA
http://www.regulations.gov

September 10, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1832–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program: Chronic Disease RFI

Dear Dr. Oz:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit comments on the calendar year (CY) 2026 Medicare Physician Fee Schedule (PFS) proposed rule to the Centers for Medicare & Medicaid Services (CMS). 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 bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. AGS advocates for policies and programs that support the health, independence, and quality of life of all of us as we age.

AGS has submitted comments separately about specific policy issues in the proposed rule. This letter focuses on the request for information about chronic disease. Per the Trump Administration's Executive Order, "Establishing the President's Make America Healthy Again

Commission," better receipt of recommended prevention services and effective management of chronic disease is a top priority for CMS. Having a usual source of primary care can be positively associated with both of these goals. We appreciate CMS' recent efforts to promote team-based primary care coding and payment. AGS strongly supports CMS' ongoing efforts to recognize the resources required to furnish primary care and to meet the complex needs of patients with chronic conditions. We believe that recent actions such as the implementation of the add-on code recognizing visit complexity, G2211, and the Advanced Primary Care Management (APCM) codes appropriately provide additional payment for primary care generally and better allow primary care teams to consider recommendations for the well-being of the whole person.

We respond to some of the particular questions CMS is seeking comments about below.

I. Prevention Services and APCM

CMS asks how it should account for cost sharing if APCM includes both preventive services and other Part B services and whether the Annual Wellness Visit (AWV), depression screening, or other preventative services should be included in the APCM bundle. CMS also asks whether there are other changes to APCM or additional coding to further recognize the work of advanced primary care practices in preventing and managing chronic disease that it should consider.

AGS does not recommend including preventive services such as the AVW or depression screening in the APCM bundle. The APCM codes are intended to support elements of primary care that are poorly recognized under the fee-for-service payment system or are administratively burdensome to report. We believe that the practices that have the required capabilities to report the APCM codes are furnishing these preventive services to their patients, as clinically appropriate, and billing under the specific codes for those services. Including preventive services in the APCM bundle would make the APCM payment into a form of monthly capitation. The current payment rates for many preventive services, particularly the AWV, are already insufficient to cover the cost of furnishing the services. We are concerned that if the bundle were expanded to include those services, the associated increase in the APCM would also be insufficient. The result would be to further burden advanced primary care practices rather than supporting them.

However, if CMS were to add preventive services the APCM bundle, then it should not apply any beneficiary cost sharing to the APCM payment amount. We believe that even without the inclusion of preventive services in the bundle, Medicare beneficiaries should not pay coinsurance for APCM services. These services are intended to be population-based and are an investment in the Medicare program and the U.S. healthcare delivery system as a whole. Research shows that healthcare outcomes and costs in the U.S. are strongly linked to the availability of primary care physicians. According to the 20th report of the Council on Graduate Medical Education on Advancing Primary Care, studies have found that patients with access to a regular primary care physician have lower overall healthcare costs than those without one as well as improved health outcomes.[1] The capabilities and practices that are part of advanced primary care will benefit Medicare and its beneficiaries but will also benefit other patients in those practices and the payers

[1] Council on Graduate Medical Education (COGME). Twentieth Report to Congress: Advancing Primary Care. 2010: Available at http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf.

who contract with them. Certain Medicare beneficiaries should not have to pay 20 percent of those costs while other patients and payers, including some Medicare Advantage plans, pay nothing.

II. Accountable Care Organizations and APCM

CMS asks whether it should consider new payments to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) for prospective monthly APCM payments to be delivered to primary care practices that satisfy the APCM billing requirements, with those payments reconciled under the ACO benchmark. CMS also requests how it should consider consent for APCM in the context of ACO payment.

AGS recommends that CMS consider additional payments to ACOs for APCM services. Many ACO participants have funded the type of care capacity recognized under the APCM codes by using MSSP shared savings or per member per month payments from Medicare Advantage. If APCM funds are not added to the APCM benchmark, the APCM payments contribute to expenses and degrade the shared savings. Effectively the participants, not CMS are then funding the APCM. Our members who participate in MSSP experienced this cost shifting under other primary care payment models, such as CPC+.

We also reiterate concerns that we have shared with CMS in other comment letters about the attribution methodology under the MSSP. In particular, AGS continues to be concerned about the impact of CMS' current policy regarding the taxonomy for non-physician practitioners (NPPs) on assignment under the MSSP and other programs. Under this policy, advanced practice nurses and physician associates working with physicians are generally assumed to be primary care practitioners regardless of the nature of their practice. AGS notes that this taxonomy may distort the assignment of beneficiaries under the MSSP because NPPs who work with specialty physicians appear to be primary care practitioners. As a result, an ACO may be held accountable for care furnished to a beneficiary whose care is not being coordinated by the primary care members of the ACO. We recommend that CMS refine this policy to address these concerns and have communicated with the National Uniform Claim Committee staff about creating taxonomy codes that better describe a practitioner's practice. Simple classifications could be primary care, specialty care, and behavioral health, designations that are commonly used in Medicare Advantage plans. We believe this approach would have the added benefit of allowing CMS to better understand the workforce.

We note that APCM codes are already used in attribution and require consent. CMS should consider whether reporting of an APCM should be the primary means of attributing beneficiaries to an ACO.

III. Supporting Prevention and Management of Chronic Disease

The key to supporting prevention and management of chronic disease, including self-management, is to continue to support team-based primary care. Such care is patient-centered and enables effective shared decision-making. Team-based care often incorporates community-based organizations (CBOs) which are particularly important in addressing social factors that affect health, such as isolation. HHS should increase support for programs funded by the Administration for Community Living (ACL) to ensure that CBOs are widely available to provide these services,

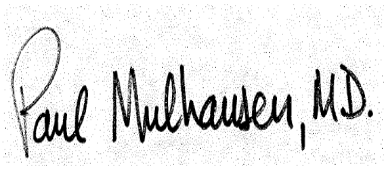
which can include addressing nutrition issues and facilitating receipt of preventive services. Program such as Meals-on-Wheels are critically important to helping seniors maintain a healthy lifestyle.

However, AGS does not recommend creating new coding and payment options under the PFS for such services or for other targeted services, such as medically-tailored meals or motivational interviewing. The PFS is intended to pay for the services of health care practitioners and it already faces significant challenges in paying appropriately for those services under the limitations established by Congress. Adding services furnished by other entities will only further tax the PFS and undermine efforts to support primary care. In addition, we believe motivational interviewing can be reported under existing E/M codes.

* * * *

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

Sincerely,



Paul Mulhausen, MD
President

Nancy E. Lundebjerg, MPA
Chief Executive Officer