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

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Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1848–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Medicare and Medicaid Programs; CY 2027 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

Dear Dr. Oz:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit comments on the calendar year (CY) 2027 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 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.

AGS appreciates ongoing efforts by CMS to improve patient care, particularly care for chronic conditions, and for its continued support for primary care. In particular, we applaud CMS for proposing to refine the site of service differential policy to pay consistently for evaluation and

management (E/M) services in nursing facilities regardless of whether the beneficiary is in a stay covered by Medicare Part A. We also support the proposal to convert the complexity adjustment add-on code G2211 to a modifier.

We strongly support the continuation of the Advanced Primary Care Management (APCM) codes and payment and applaud CMS for its careful consideration of ways to support primary care. As primary care practitioners who specifically treat Medicare-aged patients, we want to continue to work with CMS to develop payment policies that support team-based primary care focused on the health and well-being of the whole person, addressing what matters most to the individual. Additional support for primary care is critical given the statutory design of the PFS, which, unlike other Medicare payment systems, does not include an annual inflation update. As a result, PFS payments are declining even though the cost of furnishing medical care continues to increase. This situation creates challenges for clinicians who see Medicare patients but is particularly dire for geriatrics professionals for whom Medicare makes up the overwhelming majority of our patients. We urge CMS to continue to increase investments in primary care infrastructure and develop payment policies that support the provision of cognitive services. Our specific responses to the requests for information on primary care redesign and intensive lifestyle interventions to slow progression of Alzheimer's disease are provided in separate comment letters.

Below is a summary of our comments on specific proposals for CY 2027 followed by additional discussion of these recommendations. AGS recommends that CMS:

- Improve transparency about the effect of changes to the PFS methodology by showing the specific impact of any proposed or final change by specialty and by each change;
- Finalize the proposal to refine the site of service differential policy to pay consistently for the nursing facility evaluation and management (E/M) services (99304 – 99316) regardless of whether the beneficiary is or is not in a Part A stay;
- Not create a new modifier to identify employed physicians;
- Finalize the proposal to allow teaching physicians to bill for services on the telehealth list when either the resident or teaching physician has a virtual presence;
- Finalize the proposed transition of the add-on code G2211 to the modifiers MOD1 and MOD2 and consider whether these concepts should be further refined to include care for high need patients;
- Finalize improvements to the valuation of preventative and mental health services (Smoking and Tobacco Use Cessation (CPT codes 99406, 99407) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) (HCPCS codes G2011, G0396, G0397), Psychiatric Collaborative Care Model (CoCM) (CPT codes 99492, 99493,

99494, G2214) and APCM Behavioral Health Integration (BHI) add-on codes (HCPCS Codes G0568, G0569);
- Finalize the proposal to establish codes for shared medical visits and provide additional guidance to ensure those codes are billed appropriately;
- Clarify the differences between the existing coding structure that covers payment for services to diagnose and manage adverse effects after vaccination and the proposed GADV1 code;
- Finalize the proposal to value the CPT codes for health coaching (CPT codes 0591T, 0592T, and 0593T);
- Finalize the proposal to allow all levels of outpatient/office (O/O) E/M visits to be furnished under the primary care exception for teaching physicians;
- Maintain the existing G codes for caregiver training services;
- Create a G code to describe structured physician counseling regarding clinical trial eligibility, options, risks and benefits;
- Not finalize creation of new G codes to describe Advance Care Planning Services performed by clinical staff;
- Consider functional status, patient frailty and caregiver stress regarding eligibility criteria for community-based palliative care;
- Continue to rely on the CPT code set for Medicare claims;
- Address attribution problems under the Medicare Shared Savings Program (MSSP) caused by taxonomy for non-physician practitioners; and
- Ensure quality measures consider the complex needs of older adult patients and prioritize patients' goals and preferences.

I. Improve Transparency Regarding the Effect of Changes to the PFS Methodology

The PFS rate-setting methodology, particularly the methodology for determining indirect practice expense (PE), is a complicated, multi-step process that is challenging for stakeholders to replicate. In rulemaking for both 2026 and 2027, CMS proposed significant changes to the long-standing methodology. Those changes include application of an efficiency adjustment and site of service differential policy for 2026 and the elimination of the Indirect Practice Cost Index (IPCI) and the creation of a practice expense stabilization adjustment for 2027.

We urge CMS to provide a more specific understanding of the impact of each methodological change by specialty. In the impact analysis for both 2026 and 2027, CMS presented the combined impact of all of the proposals in the rule -- the methodological changes and all other proposed changes such as recognition of new codes, changes in direct inputs for specific codes, refinements to payment policies, etc. -- on work, PE, and malpractice relative value units (RVUs) for each specialty. This approach obscures the impact of any individual policy and is particularly problematic when the impact of one change is offset by other, unrelated changes. The methodological changes affect all services and result in redistribution of spending across the PFS.

Those changes impact clinicians differently depending on the type of care they furnish and the clinical setting in which they practice.

In order to facilitate a better understanding of methodological changes and therefore obtain more meaningful comments on those changes, we urge CMS to present specific information on the impact of each such change by specialty as well as the total impact of all changes under the proposed and final rules. We also urge CMS to provide examples about how methodological changes will affect different services. For example, CMS proposed a PE stabilization adjustment that is intended to limit the change in PE RVUs from year to year to 5 percent. However, we note that the change in the facility PE RVUs between 2026 and the proposed RVUs for 2027 for Level 2 and Level 3 established patient E/M visits (99212 and 99213) is 12 percent. We are unclear how the stabilization adjustment is applied and whether the observed change indicates an error in the PE calculation. Providing more granular information will enable stakeholders to better assess the accuracy of CMS' proposed values and determine whether corrections or refinements are needed.

II. Site of Service Differential Policy

a. Nursing Facility E/M codes

In 2026, CMS finalized a site of service differential policy which changed the valuation of services furnished in the facility setting. For each service valued in the facility setting under the PFS, CMS reduced the portion of the facility indirect PE RVUs that are allocated based on work RVUs in half.

AGS brought to CMS' attention an unintended consequence of this policy for clinician visits in nursing facilities. The result of the 2026 policy is to pay a clinician differently based solely on whether the beneficiary is in a stay covered under Part A. Beneficiaries in a Part A stay under the skilled nursing facility (SNF) benefit are considered to be in a "facility" setting for purposes of clinician payment whereas beneficiaries whose nursing facility care is not covered by Part A are considered to be in a "non-facility setting". However, the service of caring for a patient in a healthcare institution is the same in both settings and requires the same practitioner practice resources, regardless of whether the patient's stay is covered by Medicare Part A or some other source.

In this rule, CMS states that it is more accurate for nursing facility and SNF visits to be paid the same, regardless of the beneficiary's Part A status. For 2027, CMS is proposing to set the facility PE RVU rate equal to the non-facility PE RVUs for nursing facility care E/M codes.

We applaud this proposal and appreciate CMS' responsiveness. We urge CMS to finalize that the facility PE RVUs for nursing facility care E/M codes (99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, and 99316) will be the same as the non-facility PE RVUs for the same code, as proposed.

b. Refinement of Site of Service Differential Policy

CMS asked for comment on how costs vary for clinicians when they are employed by health systems, hospitals, or other entities and whether a new HCPCS modifier is appropriate to identify facility services furnished by an employed clinician and reduce the PE for the services they perform in the facility setting. AGS does not believe such a modifier is necessary or appropriate.

Numerous different financial and contractual relationships exist in today's healthcare environment. Clinicians may be in a small private practice, a large group practice, an employee of a healthcare delivery system, under contract with a healthcare delivery system, employed by private equity, etc. Regardless of the relationship, there are practice expense costs incurred by the clinician in furnishing services to Medicare beneficiaries. These costs may be borne directly or indirectly through budget and compensation considerations in larger organizations. We are not aware of any resource that breaks out PE costs based on employment status and therefore do not believe CMS could accurately adjust PE RVUs for that characteristic. As a result, if CMS were to create a modifier for employed clinicians, it would increase burden on clinicians but would not improve the accuracy of Medicare payments.

AGS recommends that CMS not develop or implement such a modifier.

III. Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

In the CY 2026 PFS final rule, CMS finalized that it will permanently allow teaching physicians to have a virtual presence in all teaching settings, when the service is a three-way telehealth visit with the teaching physician, resident, and patient in different locations. For 2027, CMS proposes to modify the policy to also allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary.

AGS supports this proposal and urges CMS to finalize it. We agree that it is likely to be used rarely but may help facilitate access to care in those situations that qualify. CMS should define physical presence as being in the same room as the beneficiary. We also ask that CMS to clarify that a patient can receive a telehealth service while the teaching physician and trainee are in the same room ("over the shoulder supervision").

IV. E/M Visit Complexity Add-on Code (G2211)

AGS greatly appreciates CMS' recent efforts to better recognize the additional complexity that is inherent in certain E/M services, particularly those services that serve as the continuing focal point for all needed health care services. CMS now believes that paying for that complexity at a flat rate through the add-on code G2211 does not reflect the variation in work of the various E/M visit levels. CMS proposed to replace G2211 with a modifier that will adjust the visit payment by 16 percent. A separate modifier is proposed for services furnished through an Accountable Care Organization (ACO), which will be subject to a higher adjustment (32 percent).

AGS supports this proposal. We agree that proportional adjustment (rather than a flat fee) will better reflect the increased complexity associated with higher level E/M visits. We also strongly support continuing to allow the modifier to be reported with home/residence E/M codes as well as for O/O E/M visits. We urge CMS to finalize the modifiers as proposed and to allow the modifiers to be billed with Modifier -25 for a service on the same day as an annual wellness visit, vaccine administration or any Part B preventative service is furnished. In future rulemaking, AGS urges CMS to consider further refinements to better reflect complexity associated with high need beneficiaries, for whom the added cost of care is likely similar to that of furnishing care within an ACO. AGS recommends looking at the definition of high needs beneficiaries used for beneficiary attribution in CMMI's Long-Term Enhanced ACO Design (LEAD) model, which describes beneficiaries with complex, high-utilization, and high-risk care needs, primarily dually eligible and homebound/home-limited individuals**.**

V. Valuation of Preventative and Mental Health Services

In the CY 2024 PFS final rule, CMS finalized an increase in the valuation for timed behavioral health services under the PFS by applying an upward adjustment of 19.1 percent to the work RVUs for time-based psychotherapy codes. CMS believes a similar adjustment is warranted for smoking and tobacco use cessation counseling (99406, 99407) and screening, brief intervention, and referral to treatment (SBIRT) services for alcohol and other substance misuse (G2011, G0396, G0397). CMS also proposes to better recognize the medical decision-making performed as part of the psychiatric collaborative care model (CoCM) and increase the work RVUs for CPT codes 99492, 99493, 99494 and HCPCS codes G2214, G0568, G0569.

AGS strongly supports appropriate payment for preventative and mental health services. We recommend that CMS finalize the work RVUs as proposed.

VI. Shared Medical Appointments

CMS proposed to create a G code (GSMAS) to describe shared medical appointments (SMA) which offer a group-based environment in which multiple beneficiaries can receive clinical guidance while also engaging with peers facing similar health challenges. CMS proposed that the SMA would last for 60 minutes and GSMAS would be billed for each patient included in the session. CMS proposed to value GMSAS using a building block methodology combining the work RVUs, work time and direct PE for a Level 3 established patient E/M visit (99213) and multiple-family group behavior management/modification training (96202).

AGS strongly supports multi-disciplinary, team-based care which can include SMA. A new G code and appropriate payment would facilitate provision of SMA. We believe SMA are currently furnished only infrequently and therefore most clinicians are likely not familiar with the structure. We urge CMS to provide clear guidance on the components of a shared appointment, what types of clinical staff can perform different components, and what activities must occur during the visit.

VII. Vaccine Adverse Effects Management

CMS proposes establishing an add-on code, HCPCS Code GADV1, and payment for services to diagnose and manage adverse effects after vaccination that go beyond those captured in an E/M visit citing that the existing framework does not accurately reflect the clinical work. CMS also proposes adding GADV1 to the Medicare Telehealth List.

AGS believes it is important that any patient experiencing symptoms, including those that may be an adverse reaction, after vaccine administration are appropriately evaluated and treated and that clinicians are paid for providing these services.

The existing coding and payment for E/M services reflect the activities that entail this work as outlined by CMS for GADV1 — including discussion with the patient, symptom evaluation, causality assessment, creating a treatment plan, and providing resources as necessary — with appropriate level of medical decision-making or total time as well as prolonged services codes as applicable should clinician time be extensive. Clinicians, including geriatrics health professionals, routinely and regularly conduct these activities while providing care, including for reactions that follow immunization, medication, and other treatments. We encourage CMS to provide examples that would demonstrate how the existing coding and payment structures for E/M services, vaccine counseling and administration, prolonged services, and longitudinal care do not adequately capture the evaluation and management of suspected adverse effects following immunization. AGS is concerned that separate payment with the proposed GADV1 code along with existing E/M service codes may lead to overlap in payments. We recommend that CMS elaborate on the gap areas in the existing coding and payment structure that would require a separate add-on code and that does not lead to duplicative payments. We also ask that CMS provide clarification as to the differences between the existing structure and the proposed GADV1.

We are also concerned about the lack of clarity that vaccine administration and onset of any symptoms indicate a temporal relationship rather than direct causality. In the rare event that a patient experiences a suspected adverse reaction after vaccination, a clinician would report their services that appropriately evaluate and manage the reaction given such reporting is not for determining causation. Should a new non-duplicative add-on code be established, AGS urges CMS to explicitly clarify the temporal relationship between vaccine administration and any suspected adverse reaction to ensure accurate and relevant service reporting. We also urge CMS to address these concerns before adding GADV1 to the telehealth list.

Further, we urge CMS to appropriately reimburse for immunization counseling services by finalizing "A" status for codes 90XX1, 90XX2, and 90XX3. The existing E/M office visit and annual wellness services do not address the work and expense associated with immunization counseling services, a crucial element of patient education and an important part of shared medical decision-making. Patients who have questions about immunizations are best informed by discussing the advantages and disadvantages of vaccination, including potential adverse reactions, with their physicians and

NPPs. The resource costs of furnishing this counseling should be recognized and paid under the PFS like other physician services.

VIII. Health Coaching

CMS proposes to establish national payment rates for the Category III CPT codes that describe health coaching (CPT codes 0591T, 0592T, and 0593T). AGS supports establishing valuation for the Category III codes and does not believe that CMS should create G codes to describe the services. In general, having multiple codes that describe essentially the same service creates administrative complexity and unnecessary burden for clinicians. We urge CMS to avoid creating duplicative codes whenever possible. National payment for a Category III code is not unprecedented.

Health coaching would always be billed as a service incident to a practitioner service. We urge CMS to provide clear guidance about the qualifications required to be considered a health coach so clinicians can be confident that they are billing correctly for the service. Uncertainty about appropriate billing will limit utilization of this service, even with a predictable payment amount.

IX. Revisions to the Teaching Physician Policy Related to the Primary Care Exception

The current primary care exception allows payment for certain visit codes of lower and mid-level complexity provided in primary care centers by a resident without the presence of a teaching physician, if the teaching physician is immediately available. For 2027, CMS proposes that all levels of an O/O E/M service provided in primary care centers may be provided under direct supervision of the teaching physician in such cases where the teaching physician believes such care is clinically appropriate and without the presence of a teaching physician.

AGS supports this proposal and believes it appropriately defers to the clinical judgment of each graduate medical education (GME) program as to whether or not these high level visits may be performed without the personal evaluation of the patient by the teaching physician. We urge CMS to finalize it as proposed.

X. Caregiver Training Services (CTS)

CMS created new G codes to describe caregiver training services (G0541, G0452, and G0543), effective January 1, 2025. As stated in the code descriptors, the G codes describe services that are furnished without the patient present. These services cannot be reported under other E/M codes which describe care furnished to the patient themselves. We recommend that CMS maintain the codes to allow clinicians to bill for these services when appropriately furnished. When sufficient time has passed to better understand the patterns of reporting these codes, refinement may be needed.

XI. Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

CMS asks whether it should create a HCPCS G-code describing a minimum of 20 minutes of physician or other QHP time spent on clinical trial counseling and the appropriate valuation for

such a code. CMS also seeks comment on what documentation requirements should be considered for such as service, such as the trial(s) discussed and the patient's decision.

AGS supports patient-centered care and decision-making, including decision-making regarding clinical trial participation. We recommend that CMS create a G-code to describe clinical trial counseling. A potential appropriate crosswalk for the valuation of such a code could be the level 3 established patient visit code 99213.

XII. Advance Care Planning (ACP) Services

CMS proposes to create new G codes (GACP1 and GACP2) to describe Advance Care Planning (ACP) services furnished by clinical staff. CMS indicates that they are creating these codes because it has heard that ACP services reported under CPT codes 99497 and 99498 may be underutilized because some practitioners believe that only time they personally spend can count. CMS believes new coding could more accurately distinguish and value the work of the billing practitioners from time that is spent by their clinical staff in the provision of ACP services. AGS opposes the creation of these codes.

ACP is a service that should be furnished by a clinician, either a physician or qualified healthcare professional (QHP). Non-QHP staff may play a role in furnishing the service, but they should not be the primary individual engaging with the patients and caregivers. They often have a close patient (or caregiver) relationship as part of team-based care and can facilitate discussions with great skill and compassion. We recognize that the CPT code descriptor suggests that the time must be personally spent by the physician, but CMS has already clarified in rulemaking that clinical staff time can be counted and used to report the CPT codes 99497 and 99498 if the billing physician or other billing practitioner managed, participated and meaningfully contributed to the provision of the service.[1]

If there is ongoing confusion on this point, we recommend that CMS reiterate its position rather than creating new codes specifically for clinical staff time. We believe that the addition of codes for ACP clinical staff time would increase reluctance to bill 99497 and 99498 and would lead to physicians or QHPs being paid less for an important primary care service. CMS should not finalize the proposed G codes and instead should issue updated guidance reiterating the position that physicians and qualified health professionals may count clinical staff time in reporting ACP, if the billing physician or other billing practitioner managed, participated and meaningfully contributed to the provision of the service.

[1] "We acknowledge the broad range of commenters that stated that the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, non- physician practitioners and other staff under the order and medical management of the beneficiary's treating physician. We note that the CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services." 80 Fed. Reg. 70957 (Nov 16, 2015).

XIII. Community-Based Palliative Care Request for Information (RFI)

CMS indicates in this RFI that defining which beneficiaries are eligible for serious illness care is a principal challenge in palliative and supportive care and asks for feedback on this topic. AGS is generally supportive of the criteria previously recommended by the American Academy of Hospice and Palliative Medicine (AAHPM) for identifying patients with serious illness in the community. The outlined criteria is based on peer-reviewed evidence and requires both (1) a qualifying patient diagnosis(es) and (2) an indicator of unmet need, impaired function, and/or high symptom burden.[2] We also support the recommendation that additional factors that may not be available through claims data including functional status, patient frailty, and caregiver stress be considered.

XIV. Current Procedural Terminology (CPT) Request for Information (RFI)

CMS expressed concerns over the role the American Medical Association (AMA) plays on the coding for and valuation of physician services through the CPT Panel and the RUC. CMS asks questions about the impact of the CPT process on innovation in healthcare and what alternatives to the CPT and RUC processes may exist.

As a code set recognized under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CPT codes are engrained in all elements of health care claims processing. Any transition from the CPT code set to the use of another code set for outpatient services, such as ICD-10 PCS, would require extensive changes in billing and payment systems that would affect all physicians, hospitals, and health plans and be extremely disruptive and costly. AGS does not believe that the enormous administrative efforts and cost required to shift from CPT to another coding system are justified. We urge CMS to work with the AMA to address specific concerns that CMS may have about the CPT or RUC processes.

XV. Medicare Shared Savings Program (MSSP) Taxonomy for Non-Physician Practitioners

AGS recognizes the value of ACOs and we note that CMS is proposing policies to encourage development of ACOs and participation in MSSP. For ACOs to be successful, it is critical for CMS to correct issues created by the taxonomy used to determine beneficiary assignment.

Under the MSSP and other programs, advanced practice nurses and physician associates working with physicians are always classified in a different specialty than the physician with whom they practice and generally are assumed to primary care practitioners regardless of the nature of their practice. This taxonomy distorts 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 even though that beneficiary's care is not being coordinated by a primary care member of the ACO. A similar methodology was used

[2] Kelley AS, Ferreira KB, Bollens-Lund E, Mather H, Hanson LC, Ritchie CS. Identifying Older Adults With Serious Illness: Transitioning From ICD-9 to ICD-10. *J Pain Symptom Manage*. 2019; 57(6):1137-1142. doi: 10.1016/j.jpainsymman.2019.03.006. Epub 2019 Mar 12. PMID: 30876955.

under the Primary Care First (PCF) program and severely harmed participant practices by an overestimating of "leakage" because services furnished by specialist APRNs were designated as primary care. This flaw undermined the success of the PCF model.

We have previously recommended that CMS refine this policy to address these concerns and are again reiterating that recommendation. We have communicated with the National Uniform Claim Committee staff about creating taxonomy codes that better describe a practitioner's practice rather than just the education or licensure nomenclature. Simple classifications could be primary care, specialty care, and behavioral health. Such systems are used in Medicare Advantage plans already. With physician shortages, the use of advanced practice clinicians in specialty practices will only increase, and we again urge CMS to address this issue.

XVII. Patient Attribution to an ACO

CMS proposes to change the patient attribution rules in two ways. The first methodological change relates to primary care practitioners who see beneficiaries as a participant in an ACO TIN and also as a practitioner in a non- ACO TIN. There are legitimate reasons why this could occur, but it also creates an opportunity for gaming. Therefore, AGS supports the CMS proposal to remove allowed charges billed by an ACO practitioner through a non-ACO TIN from the assignment calculation.

The second revision would include additional beneficiaries as eligible for assignment to an ACO. A FFS beneficiary with at least 1 month of Part A and Part B enrollment and no Medicare group health plan enrollment during that same month could be assigned to an ACO. This revision is based on a desire to increase the number of FFS beneficiaries assigned to an ACO. CMS estimates that these changes will reduce shared savings or increase shared losses. AGS strongly supports the MSSP program as we believe it has enhanced care coordination and provides a path for geriatrics health care professionals to demonstrate their value to health care delivery organizations. Accordingly, we are very concerned about a change that might reduce the ability of organizations to participate in MSSP. While the intent is to increase the number of assigned beneficiaries, the change could instead reduce the number of assigned beneficiaries if there are fewer participating ACOs. We urge CMS to look at methods that would attenuate or eliminate the adverse effects of newer Medicare Part A and B enrollees on the financial success of the ACOs. Absent a methodology to do so, we urge CMS not to finalize the proposed change in minimum enrollment criteria.

XVIII. Updates to the Quality Payment Program

A. General Comments

Our members are on the frontlines of caring for older Americans, many of whom are living with multiple chronic conditions, serious illness, and/or with complicated biopsychosocial issues that impact well-being and health. The Geriatrics 5Ms informed the development of

the 4Ms of age-friendly care (What **M**atters, **M**edications, **M**entation, and **M**obility)[3] of the Age-Friendly Health Systems movement which seeks to reimagine the 21st century health system to provide care that is age-friendly, respects the goals and preferences of the older adult, and meaningfully and substantially includes the family caregiver in the plan of care.[4] It is vital to identify what matters most to patients and their care preferences given the impact of the choices in care that are available to patients with chronic diseases. **AGS strongly recommends CMS ensure that the quality measures meaningfully consider patients' goals and preferences as well as routine reporting of activities of daily living, particularly in the care of older adult patients with complex and multiple chronic conditions, which is in alignment with the agency's focus on important factors impacting overall health and retain focus on person-centered care.**

B. Geriatrics Specialty Measure Set

1. Previously Finalized Measures

i. Documentation of Current Medications in the Medical Record (Measure #130)

We appreciate that CMS implemented changes to the Documentation of Current Medications in the Medical Record Measure (Measure #130). We believe that replacing the medical reason value set with the Acute Health Crisis direct reference code better represents the denominator exception. **AGS continues to recommend that CMS provide a clear definition for "Acute Health Crisis" to ensure clarity considering the significance of appropriate medication reconciliation in patients with multimorbidity and polypharmacy.**

ii. Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Measure #134)

We support the Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Measure #134) measure in the Geriatrics specialty set. We also support CMS' proposal to establish a denominator exception that facilitates the documentation of previous screening for depression and follow-up care plan performed by another clinician. We believe this is in alignment with the Geriatrics 5Ms to provide age-friendly care and will improve team-based, coordinated, and person-centered care while helping to reduce

[3] Tinetti M, Huang A, Molnar F. The Geriatrics 5M's: A new way of communicating what we do. *J Am Geriatr Soc*. 2017;65(9):2115. doi:10.1111/jgs.14979

[4] Mate KS, Berman A, Laderman M, Kabcenell A, Fulmer T. Creating age-friendly health systems - a vision for better care of older adults. *Healthc*. 2018;6(1):4-6. doi:10.1016/j.hjdsi.2017.05.005

duplicative screening and advance care continuity. Depression, including depression-related cognitive impairment (i.e., pseudodementia), is an important factor under several of the 5Ms, including Mentation as well as What Matters and Medications, both of which are also important for follow-up. When the goals and preferences of the patient are consistently recognized in treatment decisions, including use of medications, age-friendly and patient-centered care is enhanced. **AGS encourages CMS to consider approaches that would support tracking depression management over time to help bolster effective care.**

CMS also proposes expanding the numerator to allow prescribed active depression medication or management intervention in place at any time during the encounter date to meet the quality action. Although a patient may have been prescribed and using anti-depressants for a significant period, it does not always imply active depression treatment which could include adjustment of the dosage or a discussion of alternative approaches during follow-up. Furthermore, antidepressants are often prescribed for older adults for indications other than depression both on and off label (e.g., trazodone for sleep, duloxetine for pain). **We believe the proposed expansion could be improved with clarification that a prescribed antidepressant was intended for treatment of depression.** While AGS is concerned that an antidepressant on the medication list could lead to an oversight of active depression management in some cases, we recognize the important efforts to improve consistency and harmonization of related measures stewarded by different entities and in turn help reduce burden for practices.

iii. Dementia: Education and Support of Caregivers for Patients with Dementia (Measure #288)

AGS is supportive of CMS proposing to update Dementia: Education and Support of Caregivers for Patients with Dementia (Measure #288) in recognition of caregivers who are not part of the licensed clinical care team and proactively provide education and resources. We understand the heavy toll of dementia on patients, care partners, and their families as well as the essential role of caregivers in patient care and outcomes. Given caregivers — including those who are not licensed — are often an integral member of a patient's care team, they should be recognized as such and equipped with appropriate support. **We recommend CMS clarify who is considered an unlicensed caregiver (e.g., paid/unpaid family member, unpaid caregiver, health proxy). We also encourage future consideration of multicomponent supports that may be furnished to caregivers, such as counseling, support groups, skills training, and linkage to community services, for more targeted resources.**

iv. Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia (Measure #476)

We believe Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia (Measure #476) is a useful patient-reported outcome measure (PROM) and that CMS' revision clarifying the assessment timing and definition of symptom improvement in the measure description and numerator is appropriate. **AGS encourages CMS to consider allowing the documentation of patient preference when symptoms are stable and treatment escalation is not desired to ensure goal concurrent care.** Value-based care is enhanced when the goals and preferences of the patient are consistent in treatment decisions as reflected in the Geriatrics 5Ms.

v. Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Measure #503)

AGS continues to be concerned about the previously finalized Gains in Patient Activation Measure (PAM®) Scores at 12 Months measure (Measure #503). AGS prioritizes what matters most to older adults, their families, and other care partners. However, the Gains in PAM® Scores at 12 Months measure may pose challenges for use by geriatricians who treat older adults with medical complexities and living with multiple chronic conditions. Due to the comprehensive approach needed to address and individualize care within the context of what matters to the older adult with multimorbidity and the potential accumulation of disease states and medications, it may be difficult for patients to keep track of and build the knowledge, skills, and confidence to manage their own health and health care.

Although AGS supports Gains in PAM® Scores at 12 Months as a measure of progress and recognizes the benefits of patient activation regardless of health status, we are concerned about the impact of cognitive issues on this PROM as well as the practicality of quantifying progress of self-management within the complexity of navigating multiple chronic health care conditions. In addition, we believe there may be a ceiling effect with this measure in instances where a patient with an established high activation score continues to make progress. **We encourage CMS to reconsider the inclusion of the Gains in PAM® Scores at 12 months in the Geriatrics measure set.**

2. <u>Proposed Measure for Addition</u>

i. SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus (Measure #TBD)

We appreciate CMS' proposal to add SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus (Measure #TBD) to the Geriatrics specialty measure set. **While AGS generally supports the addition, we believe the measure would be strengthened by the addition of 1) denominator exceptions for clinical contraindication or intolerance; 2) patient preference documentation; and 3) consideration of advanced illness, frailty, hospice, polypharmacy, and/or limited expected benefits (including treatment burden).**

C. Value in Primary Care MIPS Value Pathway

1. Proposed Measure for Removal

i. Person-Centered Primary Care Measure (PCPCM) PRO-PM (Measure #483)

CMS proposes to remove the PCPCM PRO-PM from the Value in Primary Care MVP. Although we recognize the adoption limitations related to national benchmarking as CMS cited, the PCPCM PRO-PM is still in its early implementation phase and the measure steward has reported its ability to support establishing a national benchmark through its collection of 40,000+ PCPCM surveys.[5] We believe additional time is warranted prior to finalizing removal that would allow accumulation of benchmark data or CMS to work with the measure steward in establishing a national benchmark. Considering the critically important person-centered domains in PCPCM PRO-PM that are not captured with other existing measures, we are concerned about removal of the PCPCM PRO-PM at this time. The measure takes into account domains such as care accessibility and coordination, alignment with patient preferences, and longitudinal care that reflects the patient's perspective, all of which align with CMS' emphasis on a patient-centered care approach. AGS has long advocated for the principles of person-centered care, putting patients at the center of decision-making of their health care. In order to provide whole person and person-centered care, it is essential to understand the patient holistically, including patient engagement. Without another measure to supplant the person-centered domains, this proposal may increase focus on targeting disease and detract from the push towards whole person, outcomes-based, and value-based care through quality. **We recommend that CMS retain PCPCM PRO-PM in the Value in Primary Care MVP and ensure the only measure that assesses person-centered primary care domains continue to be**

[5] Larry A. Green Center. Proposed removal of the Person-Centered Primary Care Measure Patient Reported Outcome Measure from the Merit-based Incentive Payment System. September 9, 2026.

reported. We also encourage CMS to consider working with the measure steward to establish a national benchmark that would help address the adoption limitation.

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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,

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