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–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

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.

We strongly believe that physician input is an essential component of effective rulemaking by CMS and we look forward to continuing to engage with CMS about improvements to how Medicare pays for physician and practitioner services. We appreciate CMS' careful review and consideration of comments as well as the thoughtful responses that typify the agency.

AGS appreciates efforts by CMS to improve patient care, particularly care for chronic conditions, and for its continued support for primary care. We applaud CMS for maintaining the Advanced Primary Care Management (APCM) codes and for the proposal to create new add-on codes that would facilitate providing behavioral health integration services as part of APCM. We also applaud the proposal to expand use of the complexity adjustment add-on code G2211 to include evaluation and management (E/M) services furnished in the patient's home or residence. As primary care practitioners focused specifically on Medicare-aged patients, we want to work with CMS to continue to improve payment policies that support team-based care focused on the health and well-being of the whole person.

Below is a summary of our comments on specific proposals for CY 2026. The recommendations and the additional discussion that follows are presented in the order that the issues appear in the proposed rule.

AGS recommends that CMS:

- Reconsider the proposed site of service differential policy and better target codes such as add-on codes for which no additional indirect practice expense (PE) should be allocated; if CMS finalizes the proposed policy, CMS should exclude the hospital inpatient and observation services (99221 – 99239) and the nursing facility E/M services (99304 – 99316);
- Not establish additional coding or payment for services in urgent care centers;
- Finalize the following proposed changes related to telehealth and furnishing services through audio-visual technology:
    - Removal of Step 4 and 5 from the review process for the addition of new services to the Medicare Telehealth Services List;
    - Make permanent the removal of frequency limitations on certain inpatient visit, subsequent nursing facility visit, and critical care consultation service codes furnished through telehealth; and
    - Revise the definition of direct supervision to allow the "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only) for all services described under the regulations at 42 CFR § 410.26, except for services that have a global surgery indicator of 010 or 090.
- Not finalize ending the current policy that allows teaching physicians to have a virtual presence for services that are furnished virtually and instead make permanent the current policy;
- Consider refinements to the proposed efficiency adjustment and review the list of services to which any adjustment is applicable to ensure it does not include any evaluation and management (E/M) services;
- Recognize the immunization counseling codes for payment under the PFS and assign the RUC recommended relative value units (RVUs);

- Allow the visit complexity HCPCS code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350);
- Establish the proposed add-on codes for APCM services (GPCM1, GPCM2, GPCM3) for complementary behavioral health integration (BHI) services;
- Address concerns about profiteering related to skin substitute products without bringing those products under the PFS;
- Address attribution problems under the Medicare Shared Savings Program (MSSP) caused by taxonomy for non-physician practitioners; and
- Reconsider proposals to remove quality measures that focus on wellness (e.g., food security, housing stability, transportation).

I. Proposed Payment Policies under the PFS

a. Site of Service Differential (pp. 32373 – 74)

For each service valued in the facility setting under the PFS, CMS proposes to reduce the portion of the facility indirect PE RVUs that are allocated based on work RVUs in half, beginning in CY 2026. CMS believes that continuing to allocate the same amount of indirect practice expense based on work RVUs in both settings may overstate the range of indirect costs incurred by facility-based physicians if it is now less likely that they maintain an office- based practice separate from their facility practice. CMS also cites potential double payments for expenses the facility receives as well as the practitioner. CMS views the current indirect PE RVU allocation method as potentially disadvantaging private practices and believes that employment models may have changed the proper valuation of practitioner services provided in the facility setting.

AGS appreciates CMS' intent to appropriately allocate practice expense resources. However, we are concerned about the impact that the proposal will have on geriatric professionals and other practitioners who practice in facility settings. CMS estimates that the PE RVU changes will decrease allowed charges for geriatricians in facility settings by 10 percent, which largely reflects decreases in PE RVUs for facility E/M services. The specific PE RVU changes are a significant cut in an already small number. For example, one of the nursing facility service that is most commonly furnished by geriatricians is CPT code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.* In 2025, CMS assigned 0.84 PE RVUs to 99308 and proposes to cut that amount by 23 percent to 0.65 PE RVUs in 2026. Other nursing facility and hospital E/M services are facing similar reductions.

We are most concerned about maintaining access to care for those beneficiaries in skilled and long-term care nursing facility settings. These settings already face many challenges in retaining practitioners. Additionally, our specialty has worked diligently to establish geriatric co-management

programs in acute hospital settings. These programs have reduced overall mortality while reducing costs.[1] [2] These programs would be threatened by this proposal. While some physicians practice exclusively in facility settings, most geriatric practitioners and primary care clinicians who care for nursing facility patients maintain office practices. While the PE costs for services furnished in a facility setting are less than those furnished in the non-facility setting, they are not zero, as evidenced by inclusion of direct PE inputs for those services. The indirect practice expenses may be even larger. Nursing facilities frequently communicate with the practitioners caring for their patients/residents when the practitioners are in their offices and therefore are using indirect PE and other resources. The nursing facility does not provide the resources needed for continuous care; the practitioners do.

Any concern of duplicate payment is not supported by the facts. The nursing facility codes are used to report services furnished to patients in both nursing facilities and skilled nursing facilities. The skilled nursing facility (SNF)(place of service (POS) code 31) is designated as a facility and Medicare pays the facility for the inpatient care furnished to Medicare beneficiaries. In a nursing facility (NF) (place of service (POS) code 32), Medicare makes no payment to the facility at all. But the service of caring for a patient in a healthcare institution is the same in both settings and requires the same resources. It is unclear why CMS believes it is appropriate to pay more for the service when it is provided to a long-term care resident who is privately paying or covered by Medicaid for the services provided by the healthcare facility compared to the skilled care patient.

We appreciate the challenges CMS faces in making adjustments on a code-by-code basis. AGS has advocated for revision in the PE methodology whereby indirect PE is not tied to work RVUs for certain facility procedures. For example, we note that there are 111 add-on codes (global period ZZZ) with wRVUs for services which are performed in the facility greater than 10,000 times. For example, we suggest CMS look at a ZZZ add-on code for spine instrumentation: code 22853 *Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure*. The facility PE RVUs proposed for 22853 for 2026 after the reduction are greater than the PE RVUs assigned to 99308 in 2025. It is unclear why there would be any additional practice expense with these services. There are no direct PE inputs. CMS could consider alternatives to better correlate indirect practice expenses to direct practice expenses. It may be that any facility-based ZZZ add-on has no indirect PE. It may be that all non ZZZ codes have a minimum indirect allocation and allocations above that minimum must be justified. These methods would all have greater face-value validity than the proposed change in methodology.

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[1] Sinvani L, Goldin M, Roofeh R, Idriss N, Goldman A, Klein Z, Mendelson DA, Carney MT. Implementation of Hip Fracture Co-Management Program (AGS CoCare: Ortho®) in a Large Health System. J Am Geriatr Soc. 2020 Aug;68(8):1706-1713. doi: 10.1111/jgs.16483. Epub 2020 May 11. PMID: 32391958.

[2] Mujahid, N., Mendelson, D.A., Sinvani, L., McNicoll, L. (2024). AGS CoCare®: Ortho: Orthogeriatrics Comanagement for Fragility Fractures. In: Malone, M.L., Boltz, M., Macias Tejada, J., White, H. (eds) Geriatrics Models of Care. Springer, Cham. https://doi.org/10.1007/978-3-031-56204-4_6

Finally, we do not believe employment status is relevant. Many practitioners are employed by the group they own. In some arrangements there are funds flows that are complex but do not change the fundamentals that pay relates to revenue generation less expenses. As noted, the direct and indirect practice expenses in these and many other facility services are real.

Ironically, the proposed reduction will put particular additional strain on independent primary care physicians, including geriatricians, for whom the only facility service they are likely to furnish are E/M services. By reducing already limited PE values, the proposed policy will have the unintended consequence of making it more difficult for those non-facility-based physicians to maintain their practices and could lead to further consolidation of practices into facility-based ownership.

To avoid this outcome, AGS recommends that CMS reconsider its proposal. We believe new data on indirect practice expenses and different models should be explored. However, should CMS decide to finalize this proposal, we ask CMS to exclude the facility E/M services from the proposed site of service differential policy. Specifically, we urge CMS to use the current work values to allocate indirect PE for the hospital inpatient and observation services (99221 – 99239) and the nursing facility E/M services (99304 – 99316). Such exclusion will support primary care in general and better recognize the costs incurred by non-facility based physicians in caring for patients who happen to be in a facility. We also urge CMS to consider phasing in any changes if this problematic proposal is finalized.

b. Payment for Services in Urgent Care Centers (pp. 32374 - 32375)

CMS seeks comment about whether separate coding and payment is needed for evaluation and management visits furnished at urgent care centers. AGS does not believe such coding or payment is necessary or appropriate. Urgent care centers may be appropriate sites of service in some instances but they are not intended to serve as focal points for all needed health care services or to build a longitudinal relationship with patients. The services furnished at urgent care centers are E/M services that can be appropriately reported and paid under the existing E/M codes. There is no need for additional procedure coding or payment for services furnished in this setting. Before CMS considers alternative payment mechanisms, it may be useful for CMS to establish a place of service code for "enhanced" facilities to identify the E/M, diagnostics and treatment services furnished in those facilities as well as the types of conditions treated and assess payment adequacy relative to other settings where urgent care is provided, e.g. offices.

c. Telehealth Services (pp. 32386 – 32392)

CMS proposes revising the 5-step process to review requests to add services to the Medicare Telehealth Services List in order to simplify that process and focus the review on whether a service can be furnished using an interactive telecommunications system. CMS proposes to remove Step 4 (Consider whether the service elements of the requested service map to the service elements of services on the list that has a permanent status described in previous final rulemaking) and Step 5 (Consider whether there is evidence of clinical benefit analogous to

the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system) from the review criteria.

AGS supports this proposal. We continue to believe that CMS should use discretion in adding services to the telehealth list and that not all services can or should be furnished through interactive telecommunications systems. However, we agree that Steps 4 and 5 of the current process may be confusing and difficult for requesters to meet. We also appreciate CMS' emphasis on the important role of the professional judgment exercised by physicians and other practitioners, particularly in determining whether an individual patient should receive a service via telehealth. We recommend that CMS finalize the changes to the telehealth review process as proposed.

d. Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations (pp. 32392 – 93)

CMS proposes to permanently remove the frequency limitations on certain inpatient visit, subsequent nursing facility visit, and critical care consultation service codes furnished through telehealth. AGS supports this proposal.

We strongly agree that the determination as to whether a patient can be seen via telehealth or in-person should be based on the individual patient's needs and is best made by the patient's physician or treating practitioner. The clinical appropriateness of furnishing inpatient, nursing facility, or critical care through telehealth should be determined by the clinician in the same manner as other care that can be furnished through telehealth. Evidence shows that clinicians applied their judgement in this regard appropriately during the recent pause in application of the limits and there is every reason to expect they will continue to do so. CMS should finalize the removal of the limits as proposed.

e. Direct Supervision via Use of Two-way Audio/Video Communications Technology (pp. 32393 – 95)

CMS proposes to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only) for all services described under the regulations at 42 CFR § 410.26, except for services that have a global surgery indicator of 010 or 090. CMS also asks about services with a 000-day global (e.g. endoscopies).

AGS supports this proposal. As with several other telehealth provisions in the proposed rule, this proposal allows the supervising practitioner to apply his or her clinical judgement in determining the appropriate supervision modality. We do not believe that auxiliary personnel perform 000, 010 and 090 global services and therefore the limitations are moot. "Incident-to" reporting is not

allowed for those services, so the reporting practitioner is the performing practitioner. In addition, many 000-day global services are of higher risk than 010 services.

However, we are not sure any restrictions are needed in this area. We agree that practitioners should be allowed the flexibility to exercise this judgement.

f. <u>Teaching Physicians' Billing for Services Involving Residents With Virtual Presence (pp. 32395 - 96)</u>

CMS proposes not to extend the current policy that allows teaching physicians to have a virtual presence for services that are furnished virtually. For services provided within metropolitan statistical areas (MSAs), physicians would be required to maintain a physical presence during critical portions of all resident-furnished services to qualify for Medicare payment, not just in-person services.

AGS disagrees with this proposal. AGS' vision is for a community in which older people have access to high-quality, person-centered care informed by geriatrics principles and free of ageism. The ability to appropriately supervise residents through telecommunications technology will allow us to train more clinicians in geriatric principles and concepts and improve access to practitioners who are trained in caring for older men and women. We believe such supervision can be performed appropriately and superiorly through real-time audio/video technology. We note that there is no added value to being physically present in the room with a resident who is furnishing a service virtually. If the patient is being seen through audio-visual technology, it is important that the supervising physician have similar access to the patient, not that they be present in the same physical location as the resident. In fact, the technological challenges of a hybrid meeting between patient and clinician means that there is a high probability of audio interference or the supervising physicians being inadequately able to visualize what the trainee sees.

We also note that this proposal is at odds with CMS' position on other issues of supervision through telehealth. This flexibility is not limited to services furnished virtually; the supervising practitioner is allowed to be immediately available through audio-visual technology for services that are being furnished in person by clinical staff, if such supervision is determined to be appropriate in the physician's clinical judgement. We see no reason that supervising physicians should not be able to exercise virtual presence for services furnished virtually by residents.

AGS urges CMS not to finalize the provisions as proposed and to instead extend and make permanent the current policy.

g. **<u>Efficiency Adjustment (pp. 32399 - 32404)</u>**

CMS proposes to decrease the work RVUs and/or physician intra-service time for 7,267 physician services by 2.5 percent, based upon an assumption that efficiencies in physician time over the past five years justify a payment decrease. CMS would then compound these reductions with additional reductions every three years. CMS states that it will exempt 389 codes, including time-based

services, E/M, care management, maternity care, and services on the CMS telehealth list, from this efficiency adjustment. CMS arrives at the 2.5 percent efficiency adjustment by tallying the last five years' private, non-farm, productivity adjustments in the Medicare Economic Index (MEI).

We note that geriatric medicine is one of the few specialties expected to see a gain as a result of this proposal. However, while AGS appreciates that outcome, we are concerned about the manner in which the adjustment is being made. The proposed adjustment assumes that efficiency gains are the same across all services and applies a productivity adjustment to physician and practitioner services at a time when the physician payment system is not subject to any adjustment for inflation. It also proposes to apply the adjustment indefinitely using 3-year cycles and regardless of when a particular code was last valued. We are concerned that this may undervalue services and inadequately address over-valued services. It distorts the relativity between services by changing work RVUs, even as they are being used as the basis for valuing other services. It is applied to the work in services that include E/M visits, but only the intra-service time is adjusted or expected to be efficient.

We appreciate the longstanding concern that efficiencies are inadequately addressed after the initial evaluation of new technology or as services change. Geriatric professionals often see their patients who were previously considered "too sick" or "too old" for some services become eligible for care as physicians develop experience with a particular procedure which might increase procedure times depending on the typical patient. AGS asks CMS to consider approaches such as more frequent review of high-volume services or application of an efficiency factor only to procedural intra-service work when the service is of sufficient volume to be reviewed but has not been re-reviewed by the AMA RUC. We applaud CMS for continuing to pursue policies that support geriatric healthcare professionals and access to care for beneficiaries but feel this approach creates processes that are not appropriate. We are concerned that adjustments for new efficiencies could be made with respect to E/M in the future, which would create considerable turmoil and potential harm, even though CMS proposes to exclude them in this rule.

We also believe the addendum file "CY 2026 PFS Proposed Rule Codes Subject to Efficiency Adjustment" inadvertently included codes that met the exclusion criteria, most notably GPCM1, GPCM2 and GPCM3. We ask CMS to review the list.

h. **Immunization Counseling (pp. 32431)**

CMS proposes not to recognize new CPT codes for immunization counseling (90XX1, 90XX2, 90XX3) and to maintain HCPCS codes (G0310 – G0315) created in 2022 to report immunization counseling. CMS does not propose assigning any RVUs for either the G codes or the new CPT codes.

AGS believes that immunization counseling is 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 those services with their physicians and NPPs. The resource costs of furnishing this counseling should be recognized and paid under the PFS like other physician services. CMS states it is included in

existing coding and payment but proposes to maintain G codes it does not recognize. The RUC recommended values for the new CPT codes are based upon the typical patient for whom such services would be reported and appropriately address any potential overlap with other services. Existing E/M office visit and "Annual Wellness" services do not address the work and expense associated with the new CPT codes. This policy is also notably in conflict with the goals of better recognition of the costs of office-based primary care and prevention of disease. We recommend that CMS finalize "A" status for these services and accept the RUC recommendations as CMS did publish the work RVUs. If CMS should maintain "I" status, we still ask that CMS publish the full RVU set.

i. G2211 in Home/Residence (pp. 32495 – 96)

CMS proposes to allow the visit complexity HCPCS code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350). AGS strongly supports this proposal having requested this in comment since the creation of the code. We urge CMS to finalize it as proposed and appreciate the thoughtful consideration that CMS undertook to reach this conclusion.

We also recommend that CMS consider the impact that the initial projected use of G2211 had on budget neutrality and the conversion factor. A going forward correction of the misestimate would have a greater positive impact on geriatric health care professionals and other shortage specialties/professions that many of the proposals made in this rule cycle.

j. Enhanced Care Management (pp. 32496 – 502)

CMS proposes to create optional add-on codes for APCM services (GPCM1, GPCM2, GPCM3) that would facilitate providing complementary behavioral health integration (BHI) services by removing the time-based requirements of the existing BHI and Psychiatric Collaborative Care Model (CoCM) codes.

AGS supports this proposal. We applaud CMS for creating the APCM codes and recognizing that primary care requires investment in practice capabilities in order to be able to deliver the ongoing communication and care coordination services. These are critical elements of primary care that historically have been poorly recognized under the fee-for-service payment system or are administratively burdensome to report. Creation of the proposed add-on codes will help support primary care practices that incorporate BHI services. As importantly, it also helps to remove administrative and financial barriers for expanding BHI adoption in primary care. The codes should be finalized as proposed.

CMS also asks for comment on whether prevention services should be considered APCM services and therefore be exempt from beneficiary cost-sharing. We agree with CMS that advanced primary care practices must ensure patients receive appropriate preventive services within the context of the treatment needs of the individual patient. We also believe that beneficiaries should not pay coinsurance for advanced primary care 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.[3] 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 who contract with them. Certain Medicare beneficiaries should not have to pay 20 percent of those costs while other patients and payers pay nothing.

In a separate comment letter, we address this in more detail and also address the Request for Information on the Prevention and Management of Chronic Disease.

k. Payment for Skin Substitutes (p. 32512 – 32522)

CMS proposes to revise the way it pays for products known as skin substitutes. Beginning January 1, 2026, CMS would pay for these products as incident-to supplies and pay for all products at the same rate of $125.38 per square centimeter. CMS is proposing this policy to restrict profiteering practices currently occurring in this industry and estimates it will save $9.4B per year. AGS shares CMS' concerns about "profiteering", the "skyrocketing increase in Medicare spending" and its impact on Medicare beneficiaries.

We agree with CMS that steps should be taken to restrict profiteering practices while ensuring that Medicare beneficiaries have access to needed care. At the same time, we are concerned about the impact that bringing payment for these products into the PFS as incident to supplies will have on all other physician services. Assigning RVUs and paying separately for these products using the PFS RVU methodology will distort the relativity of all PFS services and shift money towards certain wound care and away from other services, including primary care. CMS has not added additional funds to the PFS to account for the large impact current spending would have. Even with the proposal to pay for products at a flat rate, accounting for these products as incident to supplies will have a significant impact and may harm beneficiaries by reducing available funding for other services.

CMS has received comments and concerns for many years about the adverse effects that high-cost supplies have on the PFS and PE pools. Skin substitutes, typically billed in many units, are such supplies and the proposed payment methodology will worsen an already growing problem. We urge CMS to address the substantial increase in Medicare spending on skin substitutes but to do so outside of the PFS. A useful example of how CMS might accomplish this is the treatment of Part B drugs which are essential elements of drug administration services, but these high-cost items are

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

not allowed to distort the fee schedule. We also urge CMS to carefully consider the impact on beneficiary cost-sharing of any revised payment methodology.

II. Medicare Shared Savings Program (pp. 32645)

Attribution to APRN and PA practitioners: AGS continues to be concerned about the impact of CMS' current policy regarding the taxonomy for NPPs on assignment under the MSSP and other programs and are reiterating recommendations we have provided in past rulemaking. Under this policy, 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. 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. We believe a better taxonomy could be created but it is essential that CMS use this improved taxonomy, or the effort is largely pointless. 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. We believe this approach would have the added benefit of allowing CMS to better understand the workforce. The limited current taxonomy has other adverse consequences. The Primary Care First program while ending at the close of 2025 severely harmed participant practices by overestimation of "leakage" when a service is furnished by specialist APRNs. With physician shortages the use of APRN and PA practitioners in specialty practices will only increase, and it is time to address this issue or state that the matter requires statutory language modification if that is the barrier. A less desirable alternative is to use the existing patient relationship codes. We are concerned that they will be used inconsistently, however.

Codes used for attribution: We have previously suggested that codes for services that are not typically primary care in nature (e.g., principal care management) and add-on codes should not be included in the codes used for beneficiary attribution. In the case of add-on codes, inclusion of the associated base code is sufficient. In this rule, CMS proposes to use the APCM BHI and Collaborative Care add-on codes for attribution; this proposal should not be finalized as the APCM codes are sufficient.

AGS does not know the precise attribution used in every program but wishes to note that use of add-on codes could create plurality errors. For example, if an internal medicine specialist reported 99215 and 3 units of the add-on G2212 for prolonged services that might be 4 codes but only one visit. The patient's primary care practitioner could report 3 separate visits but not reach assignment by plurality in this scenario. We ask CMS to review the code list and seek comment on the principles inherent to creation of such a list so that it may be accurate while being internally consistent.

III. Updates to the Quality Payment Program (pp. 32696)

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)[4] 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.[5] 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 that CMS reconsider its proposals to remove measures that focus on wellness (e.g., food security, housing stability, transportation). This data is essential to the care of older adult patients with complex and multiple chronic conditions, and in many cases, these measures align with the agency's focus on well-being, nutrition, and social connection as important factors impacting overall health.

b. Geriatrics Specialty Measure Set

1. Previously Finalized Measures

Advance Care Plan (Measure #047)

AGS believes the previously finalized Advance Care Plan measure (Measure #047) is of critical importance in the care of older adults with multiple chronic diseases to ensure a push towards value-based care through quality. Value-based care is enhanced when the goals and preferences of the patient are consistent in treatment decisions as reflected in the Geriatrics 5Ms. While we agree with the inclusion of this measure in MIPS and support the proposed revision to collection type with MIPS Clinical Quality Measures (CQM), there is concern that removing Medicare Part B claims collection without strategies to support smaller practices (particularly those without registry-based reporting) may discourage continued participation. These groups may also have higher risk patients who would benefit from advance care planning in rural or small practices that serve underrepresented patient populations. AGS recommends that CMS ensure data collection from smaller practices given the importance of advance care plans in older adults. We also believe that the Advance Care Plan measure should move beyond documentation, which includes a small number of interventions, and move towards goal-concurrent care for older adults with multiple chronic conditions.

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[4] 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

[5] 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

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

We appreciate the additional consideration that CMS proposes for the previously finalized Documentation of Current Medications in the Medical Record measure (Measure #130) to replace the medical reason value set with the Acute Health Crisis direct reference code to better represent the denominator exception. AGS recommends that CMS provide a clear definition for "Acute Health Crisis" considering the significance of appropriate medication reconciliation in patients with multimorbidity and polypharmacy. In addition, we encourage CMS to explicitly state that patients with cognitive or functional limitations, who are at highest risk for fragmented care and unclear and inappropriate medication combinations, should stay in the denominator. Team based approaches, multi-source verification, and flexible workflows are needed to support patients in such situations and ideally would not be excluded due to acute health crises.

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

AGS appreciates that the revisions for the previously finalized Preventive Care and Screening: Screening for Depression and Follow-Up Plan measure (Measure #134) ensures non-penalization for patients with a positive screen given there are alternative causes or triggers of depression in older adults where a depression diagnosis may not be appropriate, such as thyroid issues, vitamin deficiencies, and insufficiently managed pain. The follow-up plan for older adults ensures that alternative etiologies to a depression diagnosis are explored and addressed whether it is loneliness, grief, or a medication effect (e.g., beta blocker, glucocorticoids). AGS supports the revised measure and for teams implementing clinical follow-up, we encourage clear guidance for practices to indicate that the screening was appropriately addressed, and that this is reported under the measure.

Dementia: Cognitive Assessment (Measure #281)

CMS proposes revising the previously finalized Dementia: Cognitive Assessment measure (Measure #281) description, guidance, and numerator. However, there are several areas that need clarification. It is unclear from the revised measure specifications if the assessment is a single, one-time cognitive test or an annual occurrence of cognitive testing to determine the level of cognitive decline. Given the measure requires the presence of a diagnosis of dementia *prior* to cognitive assessment, the purpose of an annual testing seems superfluous. In addition, it is not clear what assessment approach that the measure, as amended, intends to recommend – following global staging tools (e.g., Functional Assessment Staging Tool (FAST) scale) or serial cognitive tests that indicate domain-specific losses. AGS has long championed that it is important for clinicians to address cognition during goals of care discussions and make decisions about whether a formal cognitive screening test is warranted – a matter of clinical judgment – in consultation with their patients. We encourage CMS to clarify the frequency of administering cognitive assessments and the intention of assessment (i.e., cognitive testing vs. cognitive staging).

While AGS is supportive of yearly documentation of the current stage of dementia (e.g., using FAST or Clinical Dementia Rating (CDR) scale) when clinically appropriate, we are concerned about administering annual cognitive testing (e.g., Montreal Cognitive Assessment (MoCA), Saint Louis University Mental Status Exam (SLUMS)) in patients who already have diagnosis of dementia. The score on a cognitive test does not necessarily indicate a change in care management, such as medication adjustment; an indication for change would be more appropriately determined by staging tools which may be dependent on functional status. Additionally, decision-making needs to be individualized to the specific circumstances of an older adult that elicits and is guided by their values and preferences. This approach is in keeping with the principles of person-centered care, which are to put patients at the center of decision-making about the tests and treatments that they will receive.[6] Geriatricians provide early detection and assessment of cognitive impairment and work with patients, caregivers, and families to start interventions and care planning when they are most helpful. While tracking cognitive decline may be useful, the utility would be greater when action follows accordingly, such as adapting care based on the type of decline, engaging care partners, and referrals to community resources.

Furthermore, access to resources to meet health needs such as nutrition and transportation, which impact well-being as well as ability to treat all illnesses in patients, are also important considerations in dementia care, particularly in caregiving. Emerging research has shown how societal and economic conditions (e.g., food security, physical environment) may influence and be influenced by caregiving health outcomes in dementia.[7] As an example, dementia caregivers have greater challenges in engaging patients in meaningful social and physical activities, key aspects of cognition and function, when residing in low or medium-income neighborhoods compared to those living in high-income areas.[8] AGS believes that cognitive decline may be better captured and addressed by a measure that is linked to care planning and considers all factors that contribute to health and wellness.

Adult Immunization Status (Measure #493)

We appreciate CMS' proposal to include the Hepatitis B vaccine as part of the list of routine vaccinations in the previously finalized Adult Immunization Status measure (Measure #493) considering its applicability to some older adults who are at risk, which can be discussed on a case-by-case basis. At the same time, AGS continues to be concerned that there may be financial barriers for immunizations for tetanus and diphtheria; tetanus, diphtheria, and pertussis; and zoster for Medicare beneficiaries without coverage. Given the substantial cost of the immunizations, particularly for the zoster vaccine, many older adults choose not to receive the

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[6] The American Geriatrics Society Expert Panel on Person-Centered Care. Person-centered care: a definition and essential elements. *J Am Geriatr Soc.* 2016;64(1):15-18. doi:10.1111/jgs.13866

[7] Leykum LJ, Penney LS, Dang S, et al. Recommendations to improve health outcomes through recognizing and supporting caregivers. *J Gen Intern Med*. 2022;37(5):1265-1269. doi:10.1007/s1160 6-021-07247-w

[8] Gaugler JE, Borson S, Epps F, Shih RA, Parker LJ, McGuire LC. The intersection of social determinants of health and family care of people living with Alzheimer's disease and related dementias: A public health opportunity. *Alzheimers Dement.* 2023;19:5837-5846. doi:10.1002/alz.13437

vaccination. AGS recommends that CMS ensure the affordability of immunizations for all Medicare beneficiaries as well as appropriate payment for providers.

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 in addressing and individualizing 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 be self-efficacious and 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 patient-reported outcome measures as well as the practicality of quantifying progress of self-management within the complicated nature of managing various aspects of multiple chronic conditions. We encourage CMS to reconsider the inclusion of the Gains in PAM Scores at 12 months measure in the Geriatrics measure set. 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.

2. Proposed Measures for Addition and Removals

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Measure #226)

AGS supports the addition of the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure (Measure #226) in the Geriatrics specialty measure set considering the relevance of tobacco use to cancer incidence, treatment complications, and outcomes. We recommend taking into consideration the availability and accessibility of resources for tobacco cessation interventions (e.g., nicotine replacement therapy (NRT)) as behavioral support in combination with the U.S. Food and Drug Administration (FDA)-approved cessation medications increase the likelihood of successful tobacco use cessation.[9] For example, areas that are of lower socioeconomic status and rural neighborhoods have limited access to and availability of tobacco

[9] Rigotti NA, Kruse GR, Livingstone-Banks J, Hartmann-Boyce J. Treatment of tobacco smoking: a review. *JAMA*. 2022;327(6):566-577. doi:10.1001/jama.2022.0395

cessation interventions and when available, the interventions are more expensive.[10] The availability and cost of smoking cessation products and resources may be a considerable barrier in accessing supports that are crucial to treatment, particularly for those who cannot achieve successful cessation without support of a cessation product.

Screening for Social Drivers of Health (Measure #487)

AGS opposes the proposal to remove the Screening for Social Drivers of Health measure (Measure #487) from the Geriatrics specialty measure set and MIPS more generally. For our patients in geriatric medicine with complex issues and advancing age, the screening items in these measures (e.g., food insecurity, housing instability) are a critical part of the work that geriatricians do to add value to a health system and to ensure that underlying well-being of older adults with multiple chronic conditions is being met. Multiple chronic conditions often emerge from multiple adverse social and economic circumstances that exacerbate health conditions, leading to morbidity, functional decline, and eventual cascade into the need for institutionalization,[11,12] as well as higher overall health costs to the system. Data has shown that these drivers result in low-quality care such as frequent emergency department[13] and hospital use.[14,15] This screening tool can be used to risk stratify, screen early for correlated diseases, and treat aggressively for medical risk factors such as hypertension, diabetes, and mental health needs.[16] The proactive and preventative approach via risk stratification can help identify the highest risk group of Medicaid and Medicare patients for future institutionalization and to prevent the decline associated with under-recognized burden of illness at younger ages tied to societal and economic factors that impact health, improving overall well-being for individual patients and reducing system costs. AGS urges CMS not to finalize the proposal to remove the Screening for Social Drivers of Health measure that is critical to beneficiary well-being and aligns with the agency's goal to promote a comprehensive approach to disease prevention and health promotion.

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[10] Dahne J, Wahlquist AE, Smith TT, Carpenter MJ. The differential impact of nicotine replacement therapy sampling on cessation outcomes across established tobacco disparities groups. *Prev Med.* 2020;136(106096):1-6. doi:10.1016/j.ypmed.2020.106096

[11] Hajek A, Luppa M, Brettschneider C, et al. Correlates of institutionalization among the oldest old - evidence from the multicenter AgeCoDe-AgeQualiDe study. *Int J Geiatrr Psychiatry.* 2021;36(7):1095-1102. doi:10.1002/gps.5548

[12] Geyskens L, Jeuris A, Deschodt M, et al. J. Patient-related risk factors for in-hospital functional decline in older adults: a systematic review and meta-analysis. *Age Ageing.* 2022;51(2):1-9. doi:10.1093/ageing/afac007

[13] McCarthy ML, Zheng Z, Wilder ME, et al. the influence of social determinants of health on emergency departments visits in a Medicaid sample. *Ann Emerg Med.* 2021;77(5):511-522. doi:10.1016/j.annemergmed.2020.11.010

[14] Blalock DV, Maciejewski ML, Zulman DM, et al. Subgroups of high-risk Veterans Affairs patients based on social determinants of health predict risk of future hospitalization. *Med Care.* 2021;59(5):410-417. doi:10.1097/MLR.0000000000001526

[15] Canterberry M, Figueroa JF, Long CL, et al. Association between self-reported health-related social needs and acute care utilization among older adults enrolled in Medicare Advantage. *JAMA Health Forum.* 2022;3(7):e221874. doi:10.1001/jamahealthforum.2022.1874

[16] Chang E, Ali R, Seibert J, Berkman ND. Interventions to improve outcomes for high-need, high-cost patients: a systematic review and meta-analysis. *J Gen Intern Med.* 2022;38(1):185-194. doi:10.1007/s11606-022-07809-6

Preventive Care and Wellness (composite) (Measure #497)

AGS supports CMS' proposal to remove the Preventive Care and Wellness (composite) measure (Measure #497). While we believe that clinicians should be actively engaging in addressing preventive care and wellness to support overall patient health, a composite measure that groups seven sub-categories of wide-ranging areas of health may not be conducive to encouraging adherence to the individual preventive care activities covered in the measure or appropriately account for the unique circumstances of older adults that may make certain preventive measures inappropriate.

Connection to Community Service Provider (Measure #498)

We are concerned about CMS' proposal to remove the Connection to Community Service Provider measure (Measure #498) from the Geriatrics specialty measure set and MIPS generally. Although there may be variability of the measure, we believe this is a high priority and would be beneficial even as a process measure. Connecting patients with resources, such as a community service provider, is an important step in helping to address positive screens of factors that impact overall health, including nutrition and social connection, which align with CMS' focus on wellness and prevention. AGS recommends keeping this measure and that the interventions to address these factors be evidence-based and tracked for improving access.

Adult COVID-19 Vaccination Status (Measure #508)

CMS proposes to remove the Adult COVID-19 Vaccination Status measure (Measure #508) from the Geriatrics specialty measure set and MIPS generally. AGS believes that vaccination is important to reduce morbidity and mortality caused by COVID-19 and recommends retaining this measure as we support vaccination for older adults particularly those who are at higher risk of poor outcomes and given the recent approval by Food and Drug Administration (FDA) for updated COVID-19 vaccines. We also encourage CMS to continue to reevaluate and update the measure each year accordingly as new evidence emerges.

c. Well-being and Nutrition Measures RFI

AGS applauds CMS' approach to emphasize person-centered care in promoting well-being through measures assessing well-being and nutrition for future years. We have long advocated for the principles of person-centered care which are to put patients at the center of decision-making of their health care. In order to provide whole person and person-centered care, it is critically important to understand the patient holistically, considering the complexity of the multiple conditions, medications, symptoms, as well as the patient's values and preferences.

In its request, CMS highlights that well-being is a comprehensive approach to disease prevention and health promotion, integrating mental and physical health while emphasizing preventative care. As highlighted above, the Screening for Social Drivers of Health (Measure #487) includes elements of food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety, all of which contribute to well-being. AGS recommends including Measure #487 as a Well-being and Nutrition measure for future years.

The Annual Wellness Visit (AWV) provides time for clinicians and older people to discuss the steps they can take to prevent or delay the onset of serious illness. CMS should consider incorporating the tools and assessments included in AWV into measures for well-being and nutrition given that they include questions such as daily intake of fruits and vegetables, frequency of eating out, and exercise. While emotional health screening is included via the Patient Health Questionnaire-2 (PHQ-2) and PHQ-9 in the AWV, the Geriatric Depression Scale may be more appropriate for older adults considering the scale includes social connections and purpose and can bolster other questionnaires that are a part of the AWV. However, a study found that AWVs are not economically feasible for all who practice in primary care settings, often hampered by administrative challenges, and most often conducted with patients who are healthier.[17] Should CMS consider the tools included in AWVs in measuring well-being and nutrition, AGS recommends that the frequency or time allotted and payment are increased for wellness visits given the broad range of services that clinicians are expected to provide to ensure these measures are being addressed adequately.

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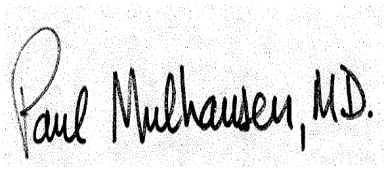
The AGS appreciates the opportunity to provide the above comments and recommendations. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,



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Chief Executive Officer

[17] Hamer MK, DeCamp M, Bradley CJ, Nease DE Jr., Perraillon MC. Adoption and value of the Medicare annual wellness visit: a mixed-methods study. Med Care Res Rev. 2023;80(4):433-443. doi:10.1177/10775587231166037