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

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

September 9, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-P)

Dear Administrator Brooks-LaSure:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments on the calendar year (CY) 2025 Medicare Physician Fee Schedule (PFS) proposed rule.[1] 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 provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the PFS.

The AGS applauds the proposal by the Centers for Medicare & Medicaid Services (CMS) to provide payment for advanced primary care management (APCM) services. AGS believes that a high-quality, cost-effective healthcare system results from care that is person-centered, team-based and grounded in strong primary care. From our perspective, as called for in the National Academies of Science, Engineering and Medicine (NASEM) report, "Implementing High Quality Primary Care: Rebuilding the Foundation of Health Care", the payment system must value primary care and be

[1] 89 Fed. Reg. 61596 (July 31, 2024)

focused on the health and well-being of the whole person across settings of care. The APCM proposal recognizes elements that AGS considers to be vital components of primary care, including team-based care and an ongoing, longitudinal relationship with the patient. The proposal supports four major goals in advancing primary care: proper resource allocation and valuation, stimulating advanced primary care, recognition of the resources required in caring for those with social complexity and administrative simplification. By implementing the proposal in 2025 CMS advances better care now, without delay. **We strongly urge CMS to finalize the proposed codes and valuation for APCM for CY 2025.** We also suggest some refinements and clarifications to ensure that those services are correctly reported, and CMS' intentions are clear to practitioners, compliance officers and Medicare contractors to avoid misinterpretations that could undermine the objectives of these landmark changes. In the body of this letter, we discuss our recommendations in detail, but we would like to highlight two overarching requests for guidance here. Specifically:

- Provide additional guidance that clarifies that APCM codes can be reported for a month when the practice has established an ongoing care relationship, obtained consent, and maintains the required capabilities even in months when no APCM service is furnished; and

- Provide clear guidance to Medicare Administrative Contractors (MACs) about expectations regarding billing for APCM and review of claims that include APCM services to promote consistency across contractors and ensure practitioners have confidence that they are billing for services correctly and their claims will be properly adjudicated.

Our recommendations for refinement and/or clarification are discussed in greater detail in section I.E below. In addition to APCM, we also comment on other provisions of the proposed rule in the order in which those issues are discussed in the proposed rule. In summary, AGS supports:

- Refining the practice expense (PE) methodology so that indirect PE is no longer allocated based on supplies and equipment;
- Adding codes for caregiver training services to the Medicare Telehealth Services List as proposed;
- Pausing application of frequency limitations on telehealth subsequent care services in inpatient and nursing facility settings for 2025 as proposed and making the removal of those limitations permanent;
- Revising the definition of "interactive telecommunications system" at §410.78(a)(3) to include two-way, real-time audio-only communication technology as proposed;
- Expanding the primary care exception for 2025 to include both higher level evaluation and management (E/M) visits and preventive services;
- Refining the clinical labor inputs recommended by the Relative Value Update Committee (RUC) for annual screening services for alcohol use (G0442, G0443) and for depression (G0444) as proposed by CMS;
- Establishing the proposed new G-codes for caregiver training and providing guidance about how any third-party entities who furnish this service should be integrated into the billing practitioner's practice;

- Allowing payment of G2211 when an office/outpatient (O/O) E/M service is furnished on the same day as an Annual Wellness Visit (AWV), vaccine administration or Medicare Part B preventive service as proposed;
- Allowing payment of G2211 when an E/M service is furnished in a patient's home or residence;
- Establishing new G-codes for Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment and management as proposed;
- Refining the taxonomy for non-physician practitioners to facilitate more accurate beneficiary attribution under the Medicare Shared Savings Program (MSSP);
- Revising the definition of individuals who are at intermediate risk of contracting hepatitis B to include an individual who has not previously completed the hepatitis B vaccination series or whose vaccination history is unknown as proposed;
- Expanding the colorectcal cancer screening benefit as proposed;
- Extending the exclusion of prescriptions written for a beneficiary in a long-term care facility from requirements for electronic prescribing through January 1, 2028 as proposed;
- Allow rural health centers (RHCs) and federally qualified health centers (FQHCs) to bill individually for care management services, include the new APCM service, as proposed; and
- Reconsidering the appropriateness of including the Kidney Health Evaluation (Measure #488), Depression Remission at Twelve Months (Measure #370) and Gains in Patient Activation Measure (PAM®) Scores at 12 Months (#243) in the Geriatrics Specialty Measure Set.

We will respond to CMS' request for information on hybrid payment for advanced primary care services separately.

I. Proposed Payment Policies under the PFS

A. Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology (II.B.5)

AGS appreciates CMS' continued engagement with the physician community as it works to update the PE methodology and awaits information from the Physician Practice Information Survey (PPIS) being conducted by the American Medical Association (AMA). We continue to support delaying updates to the Medicare Economic Index (MEI) or to use of the MEI shares in the PE methodology until the survey results are available.

We agree with CMS that the data used in the PE calculation should be updated in a predictable and timely fashion and we share CMS' concern that use of invoice submissions to update cost assumptions for supplies and equipment may distort relativity across the fee schedule. As we commented in previous years, we reiterate our recommendation that CMS **no longer allocate indirect PE based on supplies and equipment. We also recommend that CMS not allocate PE based on physician work in the facility setting. AGS believes that these refinements would result in payment rates that would more accurately reflect PE costs.**

CMS also solicits comments about the need for potential refinements to the data collected under the PPIS. Because the data from the PPIS is not yet available, we do not have recommendations for specific aggregations or other adjustments CMS should make at this time. However, we appreciate that CMS is proactively considering potential refinements to improve the PE calculation and may make additional recommendations in the future.

B. Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (II.D)

1. Changes to the Medicare Telehealth Services List (II.D.1.c)

CMS proposes to add codes for caregiver training services (97550, 97551, 97552, 96202, 96203, GCTD1, GCTD2, GCTD3, GCTB1, GCTB2; CPT code 97551) to the Medicare Telehealth Services with provisional status. The AGS agrees that caregiver training services are similar to services on the Telehealth List and are appropriate for provision through two-way interactive communications technology. We urge CMS to finalize the addition of caregiver training services to the Telehealth List.

2. Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations (II.D.1.d)

CMS proposes to continue the pause in the application of frequency limitations on certain inpatient visit, subsequent nursing facility visit, and critical care consultation service codes furnished through telehealth that began under the COVID-19 public health emergency (PHE). CMS asks for input from interested parties about concerns regarding the potential acuity and complexity of the patients receiving those services and how such acuity and complexity should influence its implementation of frequency limitations.

The AGS continues to believe that the frequency limitations are not based on clinical need or quality and may perversely impede access to clinically appropriate care. We believe 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. 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 PHE[2] and there is every reason to expect they will continue to do so.

We also note that the regulations continue to require that a physician or a NPP see nursing facility patients in person every 30 days for the first 90 days and then every 60 days thereafter.[3] We believe that this requirement provides sufficient guardrails for how care is furnished to these patients and no further restrictions are needed or appropriate. We urge CMS to finalize the pause in application of the limitations for 2025 and to make the removal of the limitations permanent.

---

[2] Ulyte A, Mehrotra A, Wilcock AD, SteelFisher GK, Grabowski DC, Barnett ML. Telemedicine Visits in US Skilled Nursing Facilities. JAMA Netw Open. 2023;6(8):e2329895. doi:10.1001/jamanetworkopen.2023.29895

[3] 42 C.F.R 483.30(c).

3. Audio-Only Communication Technology to Meet the Definition of ''Telecommunications System'' (II.D.1.e)

CMS proposes to revise the definition of "interactive telecommunications system" at §410.78(a)(3) to include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home (when the patient's home is a permissible originating site), if the distant site physician or practitioner is technically capable of using an interactive telecommunications system and the patient is not capable of, or does not consent to, the use of video technology.

The AGS supports this proposal and believes that practitioners should be able to use their clinical judgment as to whether the use of interactive audio-only technology is sufficient to furnish a Medicare telehealth service when the beneficiary is unable to use or declines to use video technology. This is not only clinically appropriate but also serves to address inequities in access to or mastery of technology by those with limitations posed by economics, region or disability. It represents one of many positive steps CMS is taking to address such matters. We urge CMS to finalize the proposed revisions to §410.78(a)(3).

4. Request for Information for Teaching Physician Services Furnished Under the Primary Care Exception (II.D.2.a.3(a))

Under the primary care exception, teaching physicians are allowed to bill for certain lower and mid-level complexity physicians' services furnished by residents in certain types of residency training settings even when the teaching physician is not present with the resident during the service, but only under certain conditions. CMS asks for input on requests to expand the primary care exception, including the addition of certain preventive services and higher-level E/M services. CMS specifically seeks comment on whether the addition of the higher-level E/M services would hinder the teaching physician from maintaining a sufficient personal involvement in the care to warrant PFS payment and whether it would impede the ability of the teaching physician to remain immediately available for up to four residents at any given time.

The AGS supports expansion of the primary care exception to include higher level E/M visits and preventive services. As we describe in our comments on the proposed creation of the APCM codes, the fee-for-service payment system is misaligned and does not adequately support primary care. As a result, there is a shortage of primary care practitioners. Expanding the primary care exception will help support training of primary care practitioners, which are the source for future geriatrics fellowship trainees and practitioners. We believe primary care graduate medical educators are dedicated to and model high quality care and show good judgement in patient management participation during primary care clinic visits. This applies to whether the trainee has only 6 months' experience or whether the trainee is weeks away for graduation. We do not believe the 6-month requirement should be changed. We also suggest CMS explicitly state that primary care teaching clinics are able to report the APCM codes, if they meet the requirements of an advanced primary care practice. It would be useful to emphasize that care continuity and empanelment are met by these clinics, even though the primary resident may not always be available and the supervising attending may not be available 12 months of the year.

We strongly recommend that CMS expand the primary care exception and do so in the final rule for 2025. The expansion should include both higher level E/M visits and preventive services. If CMS does

not expand the exception for 2025, then we recommend proposing such expansion in rulemaking for 2026.

C. Valuation of Specific Codes (II.E)

1. Telemedicine Evaluation and Management (E/M) Services (item (18)

CMS proposes not to recognize 16 of the 17 new CPT codes describing telemedicine E/M services that will take effect January 1, 2025. The codes differentiate E/M services based on the modality - audio/visual or audio only. CMS believes that the CPT language indicates that the telemedicine codes describe services that would otherwise be furnished in person which would make the telemedicine codes subject to the statutory provisions for telehealth services under section 1834(m) of the Social Security Act. Under a longstanding interpretation of the statute at 1834(m)(2)(A), CMS believes that Medicare must pay an equal amount for a service furnished using a "telecommunications system" as for a service furnished in person (without the use of a telecommunications system). If the codes were to be recognized, CMS believes it would be required to set RVUs that would correspond to the non-telehealth E/M services.

Rather than adopt this approach, CMS proposes to maintain current billing rules for telemedicine services. The administratively simple solution is to report the service using the existing O/O E/M code with the appropriate place of service (POS) code for the beneficiary's location. A modifier is applied if the service is furnished via audio-video (modifier -95) or audio-only technology (Modifier -93). CMS proposes to recognize the new CPT code describing a virtual check-in (9X091) to replace the HCPCS code G2012.

The AGS agrees that E/M services should be paid at the same rate regardless of the modality in which the visit is conducted. E/M services furnished via audio-visual or audio-only involve the same physician work and require practice expense resources. We recommend that CMS finalize the proposal to maintain the current coding requirements to report such services.

We note that the telephone service codes (99441-99443) have been deleted in CPT 2025. In the absence of a specific audio-only code, we ask CMS to confirm that audio-only services can be reported under the appropriate E/M service and identified by appending the modifier-93, subject to the requirements that would otherwise apply to those codes but no additional restrictions. We ask CMS to confirm that as proposed, the audio-only services are not subject to restrictions that were previously included in the telephone services codes, such as being furnished only to established patients and not paid separately if furnished within certain time of an in-person E/M service. We support use of the -93 modifier and consistent application of payment policies across modalities.

For the virtual check-in code (9X091) that CMS proposes to recognize, we are concerned that recognizing one code out of a family of 17 may cause confusion among providers. Additionally, CPT may respond to the CMS proposal and change the structure or guidelines for the code families which could impact 9X091. Therefore, we urge CMS to consider maintaining G2012 instead or in addition to 9X091.

2. Annual Alcohol Screening (item (28) and Annual Depression Screening (item (29))

The AMA RUC recently surveyed HCPCS codes that describe annual screening for alcohol use (G0442, G0443) and for depression (G0444). The RUC survey suggested that the clinical labor required for G0442 and G0444 would be 5 minutes. CMS proposed to refine the recommended clinical labor inputs for

G0442 and G0444 to retain the current assumption of 15 minutes because it believes that 15 minutes is more typical. The AGS supports the refinements and urges CMS to finalize the inputs as proposed.

3. Payment for Caregiver Training Services (item (39))

CMS proposes to create three new G codes for caregiver training for direct care services and supports focused on specific clinical skills aimed at the caregiver effectuating hands-on treatment, reducing complications, and monitoring the patient. Topics of training could include, for example, techniques to prevent pressure ulcer formation, wound dressing changes, and infection control. The proposed codes are:

- GCTD1 (*Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present), face-to-face; initial 30 minutes*)

- GCTD2 (*Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use GCTD2 in conjunction with GCTD1)*), and

- GCTD3 (*Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present), face-to-face with multiple sets of caregivers)*).

CMS proposes to value these services by crosswalking to existing caregiver training codes related to behavior management/modification or techniques to facilitate the patient's functional performance in the home or community.

The AGS strongly believes in the importance of the role of the caregiver in the patient's overall care and management. We supported recognition of the caregiver training CPT codes and appreciate that CMS is working to expand Medicare coverage and payment for caregiver training. We recommend that CMS finalize adoption of the proposed HCPCS codes. We also recommend that CMS publish additional guidance such as an MLN Matters guide to clarify when the caregiver training codes should be reported, including how to handle provision of different types of training furnished to the same caregiver in a single session. We believe that if the service requirements are met, multiple codes may be allowed so long as the same time is not counted twice. Additionally, these services are considered care management services and may be furnished under general supervision. CMS proposes to add them to the telehealth covered services list. There is the potential that some entities will offer training services to practices just as many external agencies offered care management services when these were first eligible for payment. We can envision a home health agency that is not providing home health services being well qualified to teach direct care and that agency having a strong partnership with a practice. We can also envision enterprises approaching clinicians offering remote training without having a greater practice affiliation. CMS has provided some guidance on how external entities must be integrated into the practice in order for the

service to be part of the patient centered care plan. We recommend that CMS clarify acceptable financial arrangements for these codes as well as roles and responsibilities, consistent with the guidance for care management codes.

4. Request for Information on Services Addressing Health-Related Social Needs (item (40))

In the CY 2024 PFS final rule, CMS established new codes describing Community Health Integration (CHI) (G0019, G0022), Social Determinants of Health Risk Assessment (SDOH RA) (G0136), Principal Illness Navigation (PIN) (G0023, G0024), and Principal Illness Navigation-Peer Support (PIN-PS) (G0140, G0146). CMS broadly requested information on the implementation of new codes for Community Health Integration (CHI) (G0019, G0022), Social Determinants of Health Risk Assessment (SDOH RA) (G0136), Principal Illness Navigation (PIN) (G0023, G0024), and Principal Illness Navigation-Peer Support (PIN-PS) (G0140, G0146) and whether there are any barriers to furnishing the services addressing health-related social needs.

AGS appreciates CMS' ongoing efforts to recognize the importance of these services to patient-centered care. We are dedicated to advancing a just society where bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. Providing payment for services that help identify and address SDOH that can limit a patient's ability to receive needed care or achieve the full benefit of health care interventions is an important step to reduce the impact of SDOH on beneficiaries.

The codes for CHI, PIN, and PIN-PS are new and practices have limited experience billing for these services. However, we note that the code descriptors for the base codes (G0019, G0023, and G0140) all require furnishing 60 minutes of the health equity service before the code can be billed. CMS may want to consider revising the code descriptors to allow reporting of the services in smaller time increments. We also urge CMS to consider whether the valuation of the code adequately reflects the resources needed to furnish these important services. We applaud CMS for continuing to monitor and evaluate the use of these codes.

D. Evaluation and Management (E/M) Visits (II.F)

1. Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

For services furnished beginning in CY 2025, CMS proposes to adjust its current policy by allowing payment of the visit complexity add-on code (G2011) when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. CMS believes that this proposal supports the agency's original policy aims, "which include paying for previously unaccounted resources inherent in the complexity of all longitudinal primary care office visits" and "building trust in the practitioner-patient relationship."

AGS agrees with this assessment. In general, we believe that G2211 should not be billed with office visit codes that are billed with the -25 modifier, which is used when an office visit is billed with a minor procedure. However, we have been concerned that this policy could create disincentives to furnish needed preventive services because it would preclude billing the complexity add-on code when the preventive services are furnished. We believe that allowing for payment of G2211 when an O/O E/M

service is furnished on the same day as an AWV, vaccine administration or Medicare Part B preventive service will eliminate the possibility of disruption to the provision of important preventive services and will align with the goals for the add-on code. We urge CMS to finalize the proposal.

2. Application of G2211 to Home or Residence E/M Services

The inherent complexity of home visits is higher than for office visits because the typical patient is sicker, has more chronic and/or severe conditions and each visit requires more extensive care management than an office visit where the clinician has more staff and administrative support. Patients receiving care in the home are typically underserved and more dependent on continuity relationships. The principles that resulted in the appropriate recognition of the additional work and other resources related to a longitudinal care relationship in primary care or in the care of a patient with a serious or complex condition are identical whether the care is in the office or the home of the patient.

Therefore, we urge CMS do the following:

- For CY 2025, allow G2211 to be billed with home visits specifically E/M services (99341, 99342, 99344, 99345, 99347-99350) furnished in the patient's home or residence subject to the same restrictions that apply to O/O E/M visits.

- For CY 2026, establish a new complexity add-on code for home visits that is valued higher than G2211. We recognize that this approach might require additional rule-making and urge CMS to propose such a code in the CY 2026 MPFS Proposed Rule.

E. Enhanced Care Management (II.G)

1. Advanced Primary Care Management (APCM)

CMS proposes three new HCPCS G-codes (GPCM1, GPCM2, and GPCM3) to recognize advanced primary care management (APCM) services stratified by the number of chronic conditions and whether or not the patient is a Qualified Medicare Beneficiary (QMB). The codes bundle certain management and communication technology-based services (CTBS) provided under an advanced primary care delivery model, which is defined as one where the practitioner is the continuing focal point for all needed health care services and responsible for all primary care services. CMS expects the proposed codes will simplify billing compared to existing care management and CTBS codes.

AGS applauds CMS for this proposal, which includes elements that we believe are vital components of primary care, including team-based care and an ongoing, longitudinal relationship with the patient. AGS members have been participants in the key care delivery models that provide the basis for the APCM proposal, including Comprehensive Primary Care (CPC), Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF). We appreciate that CMS is drawing on experience with those models to better support primary care across fee-for-service Medicare. We also applaud CMS for 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 are poorly recognized under the fee-for-service payment system or administratively burdensome to report. This lack of adequate support has resulted in few new graduates going into primary care and an insufficient number of primary care practitioners to serve Medicare beneficiaries despite a growing population.

The proposal recognizes the resources needed to provide advanced primary care. It therefore stimulates all practices advancing to this level. It is administratively simple and easily understood with the practice determining the correct code based upon their knowledge of the patient and without complex attribution mechanisms. It reduces the burden of reporting multiple care management services and continues payment for all basic E/M services such as the O/O visit codes and the Home/Residence visit codes. It recognizes the additional work and resources of caring for those with social vulnerabilities and therefore advances equity. By aligning with other advanced alternative payment programs, administrative burden of participation is reduced and these programs are promoted.

The AGS appreciates that the APCM proposal has been informed by CMS' experience with other efforts to better recognize and pay for care coordination services and feedback from interested parties on the challenges of using codes to describe those services. The complexities of billing the care coordination codes and the administrative effort needed to ensure that all requirements of the codes are met have slowed uptake of the codes and greatly limited their use. Based on this experience, we find appropriate CMS' determination that it is not necessary to adjust the conversion factor to maintain budget neutrality with the proposed adoption of these codes.

To facilitate adoption of the APCM codes, we urge CMS to provide clear guidance about when the APCM codes can be billed that will enable primary care practitioners to confidently and appropriately report the codes. As we describe below, we believe that such guidance is needed to ensure that internal and external audit expectations do not assume that every patient receives each element each month. To that end, the AGS has identified certain provisions of the proposal for CMS to clarify and refine.

We urge CMS to adopt key elements described in the rule and to add additional clarifications.

- **Adopt the APCM code descriptors and RVUs as proposed for 2025.** We believe the proposal is well reasoned and recommend that CMS finalize the codes and rates, even if the code descriptors and associated payment rates may need to be refined in the future as CMS and stakeholders gain experience with the new codes.

- **Create an optional standard beneficiary consent template.** The AGS believes that beneficiary consent and acknowledgement that a specific practitioner is intended to be the continuing focal point for all needed health care services is a critical element of primary care. To ensure that this relationship is consistently described, we recommend that CMS create a standard consent template that could be used by any practitioner who believes that they are furnishing primary care. Since only one practitioner can meet the requirement to be considered the focal point for all needed health care, use of a standard form will help beneficiaries recognize if more than one practitioner is attempting to obtain consent for APCM services. We believe this template should be optional so long as the practitioner conducts all required elements of consent. We do not believe written consent should be required nor that it should require periodic confirmation. We ask CMS to confirm that verbal consent is appropriate and once obtained does not need to be repeated.

- **Initiating visit for New Patients**. The APCM services are distinct from and provided in addition to E/M visit services furnished to the beneficiary. CMS does not propose and should not bundle payment for any E/M visit services into payment for APCM. CMS should continue to pay separately for E/M visits furnished in any setting, including in the

patient's home, and for preventive services, including the AWV; such services should not be packaged into payment for the APCM. We recommend including the AWV codes in the list of services that could serve as an initiating visit. We believe these codes were inadvertently omitted.

- **Care Continuity- APCM codes should only be billed by a practitioner who intends to be responsible for the patient's primary care and serve as the continuing focal point for all needed health care services.** We agree with CMS that practitioners who may provide ongoing care, including care for a serious, chronic condition, but who do not intend to be the focal point for all needed health care services, do not furnish primary care and should not bill for APCM services.

- **Care Continuity- Attribution of primary care designation should be based on beneficiary consent. Both practitioner and beneficiary should agree that a specific provider is acting as the continuing focal point for all needed health care services.** Attribution should not be based on utilization data. Utilization data can identify high-volume practitioners but cannot discern which practitioner is acting as the focal point for all needed health care services. Overly broad designation of certain types of practitioners (specifically nurse practitioners) as always providing primary care has led to inaccurate attribution under the Medicare Shared Savings Program (MSSP). We appreciate that the APCM proposal does not rely on the MSSP attribution methodology, and we recommend that CMS not adopt claims-based attribution in the future.

- **Patient Centered Comprehensive Care Plan.** The proposed rule suggests that all patients, including patients with only one or no chronic conditions, should have an electronic patient-centered care plan. We do not believe that this reflects current practice and is not medically necessary for less complex patients. Rather than promoting thoughtful care planning, we believe that establishing such a requirement will likely lead practitioners to rely on a standard template with data elements of little clinical relevance. Similarly, a patient with two well controlled chronic conditions would not need a perfunctory statement of goals, timeframes and responsibility assignment. This type of form and format box checking reduces the value of true care planning. As currently constructed, this element of care plans could limit the ability of practitioners to report GPCM1. We recommend that CMS clarify that for GPCM1, the care plan requirement is satisfied if the practitioner maintains an up-to-date problem and medication list for the patient, including the status of preventive services. For example, a note for the most recent annual wellness visit would suffice to meet this requirement. AGS believes this is an area of particular relevance for auditors and compliance officers who look for specific items but often lack clinical judgement skills. We appreciate that CMS lists a series of items as stated in the 2020 Final Rules describing typical care plan elements but does not require all of them. If in the final rule CMS does require a specific format with some items allowed to be listed as "not applicable" by the clinician, it is important to state that. Conversely, if CMS does not require such a format, it is important to emphasize the need for an item "when clinically relevant".

- **Management of Care Transitions.** CMS proposes that the timely follow-up communication after an emergency department (ED) visit or discharge from a hospital or healthcare facility occur within a specified time frame (7 calendar days after discharge), as

applicable. While we understand CMS' intent, it is not always possible, as we describe below, in spite of the best efforts of the practice, to communicate with the patient within 7 days. Therefore, we recommend that instead of making this a requirement, that CMS state that "**that this timeframe should be met whenever possible.**" We agree that such communication is an important part of person-centered primary care. However, the current health care system does not necessarily allow practitioners to consistently meet this standard. We agree relationships between primary care practitioners and the hospitals and emergency departments most commonly used by the practice's patient population should be promoted, but some facilities are not receptive despite their care coordination obligations. Further, if a patient receives care at a hospital that is not affiliated with the primary care practice, there can be a lag between when an ED visit or hospital discharge occurs and when the primary care practitioner becomes aware of the health care encounter. We believe that CMS expects the practice to have processes in place to address care transitions and to generally assess the need for services for patients experiencing a transition within a timely manner. We do not believe that if a transition occurs and the patient or caregiver was not contacted within 7 days that an APCM service should be denied on audit. The AGS recommends that CMS revise the requirement for communication "within 7 calendar days of discharge" to clarify that this timeframe should be met whenever possible. This understanding is consistent with the requirements of the primary care demonstration models.

- **Practitioner, Home-, and Community-Based Care Coordination.** We have the same concerns about documenting coordination communications as we stated with respect to the care plan. We agree that for complex patients who are receiving certain services most of the information listed in the documentation requirements related to the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes is needed. But many clinical referrals need only focus on the specific clinical question and some referrals to community-based social services organizations might not appropriately include some personal health information in the care plan. We believe the amount of personal health information that needs to be shared should be left to the discretion of the referring practitioner.

- **Patient Population-Level Management.** We appreciate that CMS recognizes and seeks to promote participation in advanced alternative payment programs such as the Medicare Shared Savings programs. As CMS is aware, many ACOs conduct population stratification and some management elements at the organizational level. We ask CMS to specify that the practice's population must be subject to such management but that it is not required that the management be conducted by an individual primary care practitioner. Because many primary care practices are part of larger care delivery systems and population management is performed across the organization's entire patient population it would not be appropriate or efficient for an individual practitioner to conduct population management in those instances and we ask CMS to clarify that such a care model meets the requirements of APCM.

- **Performance Measurement.** We applaud CMS for seeking a low burden way for practitioners to meet the APCM billing requirements by recognizing participation in Medicare Shared Savings programs and primary care demonstrations. We urge CMS to utilize existing quality measures and pathways and avoid creating new requirements. We

support the proposal that the performance measurement requirement can be met by reporting the Value in Primary Care MIPS Value Pathway (MVP).

- **APCM should be considered a "designated care management service" and be furnished under general supervision of a physician or NPP.**

- **Clarify when APCM codes can be reported and that by billing for the APCM services, practitioners are attesting that they have the required practice capabilities.** CMS correctly recognizes that there will be variation from patient to patient and from month to month as to what specific APCM services are needed. We appreciate that CMS proposes that APCM services can be billed when the capability of furnishing the services is maintained, even if all elements are not furnished in a given month. We believe that in some months, none of the services may be furnished, particularly for patients with only one or no chronic conditions, but that it is still appropriate to bill the APCM service in those months in order to maintain the capability of furnishing the APCM service when needed. We urge CMS to confirm this understanding in the final rule. We also ask that CMS make the process for confirming that a practice has the required capabilities as simple as possible. We recommend that CMS clarify for both practitioners and MACs that billing of the APCM constitutes an attestation that the practice meets the requirements and no further attestation or documentation is required.

- **Provide assistance to practices in identifying patients who are QMBs.** It can often be difficult for practitioners to determine whether a beneficiary is a QMB and if there are changes in QMB status. We ask that CMS provide guidance to help practitioners maintain accurate information about QMB status to ensure that the APCM codes are billed accurately. We support the proposed use of GPCM3 and do not believe it should be limited to full dual eligible beneficiaries.

- **Services included in the APCM payment.** CMS has correctly identified the services that should be in the APCM "bundle". We feel that the separate payments CMS proposes to allow are appropriate, complementary and advance equity. CMS also proposes to preclude reporting of the bundled services that are identified in Table 19 with the APCM codes for the same beneficiary by the same practitioner, or a different one within the same practice, for the same service period. We agree but urge caution in defining the same practice which may rely on specialty, NPI and tax identification numbers. CMS may erroneously identify NPPs in a multi-specialty group practice as being part of the primary care practice.

- **Qualifying Beneficiaries.** We believe it is CMS' intent that APCM services apply to beneficiaries who reside in the community whether the residence is an assisted living facility or other domicile. We do not believe it was the intent to report these services for residents in long term care nursing facilities (NF). Because CMS allows some care management services to be reported to SNF and NF patients/residents, it would be helpful for CMS to specify the populations for which these services may be reported. It would also be helpful to specify which site of service code is to be used. For example, does the practice report its site of service code or the location of the patient or the location where the patient is typically seen. We suggest using place of service codes 11, 19, 2 and 27 (and as applicable adding FQHC and RHC sites) for simplicity. In a calendar

month, a beneficiary may be hospitalized, in a SNF or initiate NF services care. We believe that in each of these cases, the advanced primary care practice is involved in care coordination, caregiver/family support or more. This would be the case even if for the entire month the beneficiary was not in their usual community setting. (Beneficiaries residing in a nursing facility at the NF level for the full month are not included, unless CMS proposes to allow APCM services for NF residents). Therefore, CMS should be clear that there is no requirement that for all days in a month the beneficiary would be able to be seen in the practice and the 24/7 care continuity requirement is met.

The AGS recommends that CMS finalize the APCM codes and valuations with these suggested refinements and clarifications. We also note that CMS included an extensive request for information (RFI) about hybrid payments for advanced primary care. We are responding to the RFI separately.

2. Cardiovascular Risk Assessment and Risk Management

Based on the success of the Million Hearts® (MH) model, CMS proposes two new G-codes for the administration of an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment for patients with at least one predisposing condition to cardiovascular disease (CVD) and ASCVD risk management services for patients who do not have a current CVD diagnosis or a history of heart attack or stroke but are at medium or high risk for CVD, as found by the ASCVD risk assessment. The predisposing conditions include, but are not limited to obesity, a family history of CVD, a history of high blood pressure, a history of high cholesterol, a history of smoking/alcohol/drug use, pre-diabetes, or diabetes. It is not clear why the assessment must be performed on the same date as an E/M and CMS proposed an XXX global. We support the proposed global and revising the descriptor so that the assessment can be performed separately, even if rarely on a day other than another E/M service.

The AGS believes that assessment of ASCVD is part of best practice of geriatric care and urges CMS to finalize the new codes.

II. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (III.B)

Since 2018, CMS has paid for care management services furnished by RHCs and FQHCs using a general code (G0511). As CMS has recognized additional care coordination and care management services for other practitioners, those services have been included in G0511 and the payment rate has been adjusted for the number of services reported under the code. For 2025, CMS is proposing to require that RHCs and FQHCs bill the individual codes for services assigned to G0511 and be paid based on the national non-facility payment rate for the code. CMS also proposes to allow RHCs and FQHCs to report the new APCM codes and would pay for those services at the PFS non-facility rate. If the RHC or FQHC report the bundled APCM codes, then the facility would not bill for individual care management services.

The AGS recommends that CMS finalize these proposals. RHCs and FQHCs are important sources of primary care for many populations. We believe that allowing RHCs and FQHCs to report care management services individually will improve transparency and better identify the specific care coordination service being furnished. It will also better recognize the role that RHCs and FQHCs play in primary care.

III. Medicare Shared Savings Program (III.G)

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. 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 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. In this NPRM CMS notes the difficulty CMS has in the QPP related to a taxonomy based on education and not clinical practice.[4] The Primary Care First program has been severely harmed by overestimation of "leakage" when a service is furnished by specialist APRNs. With physician shortages the use of APRN and PA practitioners will only increase, and it is time to address this issue or state that the matter requires statutory language modification.

Proposed Revisions to the Definition of Primary Care Services: We do not agree with the proposed addition of GSPI1, the interprofessional consultation service codes and other codes that are not predominantly primary care services to the list of Primary Care Services. While we agree that those services may be reported by primary care practitioners on a limited basis, many are almost exclusively specialist services (in some cases by design). In addition, while these services may be appropriately part of the APCM bundle, that does not make them predominantly a primary care service. We also do not believe the current list accurately reflects primary care. Aligning proposed classification with past errant classification is a concern. As they are used in attribution when performed by certain specialists and non-physician professionals, this list needs to better identify the primary care practitioner. In particular, we recommend that CMS use claims data on current codes unequivocally primary care. Codes that are not reported a majority of the time by primary care specialties should be removed from the definition of primary care services. In the future, CMS should not propose the addition of a code if available claims data does not demonstrate that the service is unequivocally a primary care service. If claims data is not available, a service should only be added provisionally and should be reevaluated for continued inclusion once data becomes available. We make suggestions for better designation methods and use examples from the current proposal.

GSPI1: We believe that this service will almost exclusively be performed by behavioral health clinicians. A patient with significant risk of suicide will receive mental health services by a mental health professional except in the most access-deprived circumstance. Further this is a ZZZ add-on code. Add-on codes should not be used for attribution. They are not distinct from the base code and would inappropriately weight the encounter. We note that CMS does not count 4 units of a time-based add-on

[4] 89 Fed. Reg. 62015 (July 31, 2024).

code as equal to four distinct encounters and should not recognize add-on codes separately from the base code.

Interprofessional Consultation Services (CPT codes 99446, 99447, 99448, 99449, 99451, 99452: These are codes where CMS has data available to determine which specialties most commonly perform them. These codes were established for the primary care clinician or hospital attending to be able to request a consult and for the consultant to use these codes when reporting their services. Primary care practitioners are not precluded from their use, but the volume by primary care practitioners was expected to be far smaller than by specialists and this is confirmed by claims data. Using 2022 data, 99446, 99447 and 99448 were most commonly reported by neurology. Even if we consider all NP and PA services to be primary care, less than 1/3 were reported by these "specialties", internal medicine and family medicine combined. 99449 was most commonly reported by Clinical Nurse Specialists for the diagnosis of major depression. 99451 is led by psychiatry. Only 99452 was intended to be primarily for the referring primary care practitioner and it is approximately 50% of the time reported by a primary care specialty.

Quality Measures: We applaud CMS for recognizing that eCQMs could disadvantage ACOs that have a more socially vulnerable population. Medicare CQMs at least level the playing field to only Medicare beneficiaries. We also are encouraged by proposals to adjust for social vulnerability as it has long been known that those who lack resources in finance, transportation, time, educational background and health literacy and English as a primary language will create challenges in outcome measures such as diabetes control. We are also appreciative that CMS understands the cost and complexity of merging multiple records systems, de-duplicating and other necessary steps to report eCQMs. However, we believe that in the MSSP programs, Medicare Advantage and MIPS MVP that CMS appears to place unwarranted confidence in simplification created by electronic medical record (EMR) certification and new technologies. Most clinicians do not share this confidence given the many unfulfilled promises of the EMR. CMS should only add new measures, including new eCQMs, after careful consideration of the costs and benefits of a specific measure. Each measure used should be evaluated from the perspective of the practitioner performing the care and creating the record. Each measure developer should be required to publish this assessment. The burden of excessive quality measurement is substantial and a major source of demoralization for primary care practitioners. This is not to suggest that performance measurement is unnecessary nor that it does not help improve care, but that the financial and psychological cost must be weighed against the benefit. That calculus must also consider the impact on the desirability of entering primary care as a career. Without primary care, high-quality efficient care is not attainable.

IV. Medicare Part B Payment for Preventive Services (Section III.H)

A. Part B Preventive Vaccines and their Administration

CMS proposes to continue recent policies intended to improve access to preventive vaccines covered under Medicare Part B (pneumococcal, influenza, hepatitis B, and COVID-19). This includes paying for vaccines not marketed under an Emergency Use Authorization declaration at a uniform rate and providing an additional payment for administration of vaccines in the beneficiary's home. CMS also proposes to revise the definition of individuals who are at intermediate risk of contracting hepatitis B to include an individual who has not previously completed the hepatitis B vaccination series or whose vaccination history is unknown.

The AGS believes vaccines and other recommended preventive services are an essential element of high-quality primary care and appreciates CMS' efforts to reduce barriers that impede access to those services. We urge CMS to finalize the proposed policies.

B. Expand Colorectal Cancer Screening

CMS proposes to expand the colorectal cancer screening benefit to include computed tomography colonography (CTC) and a follow-on screening colonoscopy after a Medicare covered blood-based biomarker CRC screening test. Specifically, CMS proposes to codify that a CTC is covered:

- in the case of an individual age 45 or over who is not at high risk of colorectal cancer, payment may be made for a screening CTC performed after at least 59 months have passed following the month in which the last screening CTC or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed;
- in the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening CTC performed after at least 23 months have passed following the month in which the last screening CTC or the last screening colonoscopy was performed.

CTC covered under the colorectal screening benefit would not be subject to beneficiary coinsurance or deductible.

The AGS supports the expansion of the colorectal screening benefit and urges CMS to finalize the expansion as proposed.

IV. Requirements for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan (III.L)

CMS requires that all Schedule II, III, IV, and V controlled substances for covered Part D drugs prescribed electronically must be prescribed using the applicable standards in § 423.160(b). Because of unique operational challenges in using the Electronic Prescribing for Controlled Substances (EPCS) Program in long-term care (LTC) facilities, CMS established that it would not pursue compliance actions against prescribers based on Part D controlled substance prescriptions written for beneficiaries in long-term care (LTC) facilities prior to January 1, 2025. In this rule, CMS proposes to extend the exclusion of prescriptions written for a beneficiary in a LTC facility through January 1, 2028.

The AGS appreciates CMS' recognition of the administrative burden associated with implementing EPCS in LTC facilities. We urge CMS to finalize the extension as proposed.

V. Updates to the Quality Payment Program (IV)

A. General Comments

Geriatrics health professionals provide care for older adults, usually over the age of 65, with complicated medical issues and social challenges. They focus on the 5Ms of geriatrics: **M**ultimorbidity, What **M**atters, **M**edication, **M**entation, and **M**obility.[5] Multimorbidity describes the older person who has

[5] Adapted by the American Geriatrics Society (AGS) with permission from "The public launch of the Geriatric 5Ms"

[on-line] by F. Molnar and available from the Canadian Geriatrics Society (CGS) at The Canadian Geriatrics Society - Geriatric 5Ms (wildapricot.org)

more complex needs often due to multiple chronic conditions, frailty, and/or complex psychosocial needs. What Matters, Medication, Mentation, and Mobility describe the four main areas where geriatrics health professionals focus their clinical attention and form the basis for the age-friendly health systems framework that is focused on ensuring that all older people have access to this type of coordinated care, while also making sure personal needs, values, and preferences are at the heart of that care.[6] It is critically important 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 conditions. **AGS recommends that CMS focus on encouraging strategies that will reinforce care centered around the 5Ms and align with age-friendly care across health systems, including in quality reporting and payment programs such as the Quality Payment Program.**

B. Geriatrics Specialty Measure Set

1. Previously Finalized Kidney Health Evaluation (Measure #488) and Depression Remission at Twelve Months (Measure #370)

AGS continues to be concerned about the previously finalized Kidney Health Evaluation measure (Measure #488) in the Geriatrics specialty measure set. While adults over 60 years of age are more likely to develop kidney disease and more than 50 percent of adults over the age of 75 are believed to have kidney disease,[7] there is strong evidence that the current definition of chronic kidney disease (CKD) leads to overdiagnosis and identifies older adults as having CKD even though they do not have an increased risk for adverse outcomes.[8,9,10] **AGS encourages reconsidering the addition of the Kidney Health Evaluation measure so as not to encourage overdiagnosis, overestimation of the burden of CKD, and unnecessary interventions in older adults.**

We also continue to be concerned about inclusion of the Depression Remission at Twelve Months (Measure #370) in the Geriatrics specialty set, particularly as it requires a Patient Health Questionnaire-9 (PHQ-9) score of less than five. We believe that it is unlikely that geriatrics patients would be in remission (as defined in this measure) compared to an improved state considering that older adults have lower rates of remission and may have other conditions such as fragmented sleep that will result in a PHQ-9 score of 5

https://thecanadiangeriatricssociety.wildapricot.org/Geriatric5Ms/.

[6] Institute for Healthcare Improvement. Age-Friendly Health Systems: Measures Guide. July 2020. Accessed August 20, 2024. https://www.ihi.org/sites/default/files/2023-09/IHIAgeFriendlyHealthSystems_MeasuresGuide.pdf

[7] National Kidney Foundation. Aging and Kidney Disease. Accessed August 20, 2024.

https://www.kidney.org/news/monthly/wkd_aging.

[8] O'Hare AM, Rodriguez RA, Rule AD. *JAMA Intern Med*. 2021;181(10):1366-1368. doi:10.1001/jamainternmed.2021.4823

[9] Liu P, Quinn RR, Lam NN, et al. Accounting for age in the definition of chronic kidney disease. *JAMA Intern Med*.

2021;181(10):1359-1366. doi:10.1001/jamainternmed.2021.4813

[10] Delanaye P, Jager KJ, Bökenkamp A, et al. CKD: a call for an age-adapted definition. *J Am Soc Nephrol*. 2019;30(10):1785-1805. doi:10.1681/ASN.2019030238

or higher.[11,12] **Thus, this may not be an appropriate measure for the Medicare population.** We believe the inclusion of the Preventive Care and Screening: Screening for Depression and Follow-up Plan measure in the Geriatrics Specialty measure set is a sufficient and more appropriate measure to support proper screening and management of depression among older adults.

2. Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood

AGS appreciates that CMS proposes to add the Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood measure in the Geriatrics specialty measure set. The patient experience of feeling heard and understood is a key goal and benefit of palliative care as well as geriatrics. Patients want to be treated as individuals and have their symptoms and goals of care managed effectively and consistent with their care preferences, which may be challenging at times given provider time constraints. This measure would help facilitate active participation from patients in defining an outcome of the palliative care received.

Geriatricians and other geriatrics health professionals care for older adults many of whom are living with complex health issues, including cognitive impairment and dementia. **While AGS supports the addition of this measure in the Geriatrics specialty measure set, we believe the exclusions should include diagnoses of cognitive impairment, dementia, and Alzheimer's disease before finalizing the Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood to take into consideration the limitations with patients who are not as engaged in their own decision-making as they may not be able to appropriately respond to the survey administered that determines the top-box score for this measure.**

3. Gains in Patient Activation Measure (PAM®) Scores at 12 Months

We appreciate CMS' ongoing efforts to include patient-reported outcome measure in the Geriatrics specialty set. 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. For example, the survey item, "I know what each of my prescribed medications do," may be difficult to adhere to considering the high prevalence of polypharmacy in the older population.[13] A 10 to 13-point survey may also be burdensome with time constraints during visits and lead to taking time away from addressing more pressing concerns raised by older patients, many of whom will have multiple chronic conditions.

---

[11] Reynolds III CF, Dew MA, Pollock BG, et al. Maintenance treatment of major depression in old age. *N Engl J Med*. 2006;354:1130-1138. doi:10.1056/NEJMoa052619

[12] Nelson JC, Delucchi KL, Schneider LS. Moderators of outcome in late-life depression: a patient-level meta-analysis. *Am J Psychiatry*. 2013;170(6):651-659. doi:10.1176/appi.ajp.2012.12070927

[13] Delara M, Murray L, Jafari B, et al. Prevalence and factors associated with polypharmacy: a systematic review and meta-analysis. *BMC Geriatr.* 2022;22(1):601. doi:10.1186/s12877-022-03279-x

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 complexity 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 health care and 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.

4. Adult COVID-19 Vaccination Status

CMS proposes to include the Adult COVID-19 Vaccination Status measure to the Geriatrics specialty measure set. AGS agrees with CMS that vaccination is important to reduce morbidity and mortality caused by COVID-19 and recommends vaccination for older adults particularly those who are at higher risk of poor outcomes, but we are concerned that the measure will add burden to clinicians without meaningful improvements in care, quality, or vaccination rates. Given the fluctuating landscape of COVID-19 and related interim guidelines, we believe that complying with the Centers for Disease Control and Prevention (CDC) recommendations that are not yet final for all patients, while ideal, would be difficult. **If finalized, we recommend CMS to explore qualifiers that take into consideration these challenges as well as the reality that the evidence is based on retrospective data that reflects the experience during a public health emergency when the disease was more deadly.**

C. Episode-Based Cost Measures

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. We believe an episodic approach to measures for patients with multiple chronic diseases may lead to treating these conditions as existing independently of one another. **AGS encourages CMS to consider cost-measure approaches that will avoid unintentionally incentivizing fragmented care.**

D. MIPS Value Pathways

We appreciate the intent of the Merit-based Incentive Payment System (MIPS) (and more recently the MIPS Value Pathways (MVPs)) to improve quality of care for Medicare beneficiaries. AGS supports preventing complications and enhancing the quality and efficiency of care provided across the healthcare continuum. However, it is not clear whether all health systems, particularly smaller practices and systems, will have the resources and infrastructure to handle such a substantial change with the eventual sunsetting of traditional MIPS and transition to MVPs. We remain concerned about potential adverse impacts on the more fragile delivery system practitioners. If the administrative burden and costs of reporting harm an already fragile primary care system, we will not achieve high quality, efficient care. The biggest threat to the health of our Medicare population is not a lower score on some measures, but the erosion and collapse of primary care. We greatly appreciate the proposals in this rule that promote primary care and ask CMS to continue to weigh the balances inherent in promoting quality.

****

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,

Mark Supiano, MD
President

Nancy E. Lundebjerg, MPA
Chief Executive Officer