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**SUBMITTED ELECTRONICALLY VIA**  
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Administrator  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
ATTN: CMS-1770-P  
Mail Stop C4-26-05  
7500 Security Blvd.  
Baltimore, MD 21244-1850

**Re: [CMS-1770-P] Medicare and Medicaid Programs: CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program; et al.**

Dear Administrator Brooks-LaSure:

The American Geriatrics Society (“AGS”) greatly appreciates the opportunity to comment on the Physician Fee Schedule (PFS) Proposed Rule for Calendar Year (CY) 2023 (CMS-1770-P).<sup>1</sup> The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our 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 and through the Quality Payment Program (QPP).

We want to start by applauding CMS’s ongoing efforts to directly address issues of health equity, including improvements to the Medicare payment policy to reduce inequities and consideration of ways to incorporate health equity into the QPP. In our statement on discrimination, the AGS opposes discrimination or disparate treatment of any kind in any healthcare setting because of age, ancestry, cultural background, disability, ethnic origin, gender, gender identity, immigration status, nationality, marital and/or familial status, primary language, race, religion, socioeconomic status, and/or sexual orientation. We believe such discriminatory policies—especially when they are perpetuated across the healthspan and lifespan—can have a negative impact on public health for us all. The AGS strongly supports the steps CMS is taking to reverse inequities, including steps to eliminate avoidable differences in health outcomes, and consider and mitigate against unintended consequences of policy changes. The AGS also appreciates CMS’s efforts to consider beneficiaries’ health care needs comprehensively, as evidenced by

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<sup>1</sup> 87 Fed. Reg. 45860 (July 29, 2022).

the proposal to codify coverage guidance related to dental services. One of our core principles is to treat older people as whole persons and appropriate oral health care is part of whole-person care.

Our recommendations are in bold text in our discussion of each section of the rule for which we are submitting comments.

## II. Solicitation of Comments on Strategies for Updates to Practice Expense Data Collection and Methodology

### A. Practice Expense Data Collection

CMS has updated components of the practice expense (PE) calculation in recent years, but those updates have been on an ad hoc basis and pricing for some individual components has been done sequentially while other components have not been updated. For example, the Physician Practice Information Survey (PPIS), which was last conducted by the American Medical Association (AMA) in 2007 and 2008 and reflects 2006 costs, continues to be a primary data source for the indirect PE calculation. In this rule, CMS indicates that it intends to move to a standardized and routine approach to valuation of PE that will be proposed in future rulemaking.

We agree that CMS should obtain updated data on practice cost expense and should establish a predictable timetable for obtaining data for future updates. **We recommend that CMS conduct surveys not more frequently than every five years.** For the survey to help CMS appropriately understand PE costs and variations, it is critical that survey participants provide accurate and complete information. Compiling and reporting such information involves time and resources and CMS should provide financial incentives to help offset the costs of survey participation. In particular, we urge CMS to appropriately capture the costs associated with population health management, the success of which is largely driven by the work of primary care practices. Primary care practices are likely tracking a much larger number of quality metrics and reporting those metrics to multiple payers in contrast to some specialists who only report a limited number of quality measures. Appropriately capturing the cost of this activity will help improve the accuracy of the Medicare payment rates.

**We also urge CMS to take into consideration the variation in the site of service within a specialty when conducting PE surveys.** For example, some AGS members see almost all their patients in the physician office while others almost exclusively see patients in facility settings such as hospitals or nursing facilities. The survey instrument should appropriately capture the variation between the two types of practices and allow for appropriate cost allocation between the different types of practice for physicians within the same specialty. That is, CMS should avoid averaging PE cost estimates in a way that is likely to understate the cost of services furnished primarily in the physician office.

### B. Indirect PE Allocation Methodology

CMS specifically seeks comments on approaches to “adjust PE to avoid the unintended effects of undervaluing cognitive services due to low indirect PE.” The AGS greatly appreciates CMS recognition that this issue needs special attention. We are concerned that the historic undervaluing of cognitive services will be perpetuated in more recent survey data. Under the current methodology, specialties that primarily furnish cognitive services receive less indirect payment and therefore have less funding available to invest in practice improvements that would be reflected in the PE costs captured by the survey. The AGS urges

CMS to refine the allocation methodology to reflect the PE costs more appropriately for both cognitive and procedural services and specialties.

We believe that the current methodology for determining PE Relative Value Units (RVUs) uses several elements that are not associated with increased indirect PE. For example, the AGS believes that the use of disposable supplies, especially expensive supplies, and equipment is not relevant to allocating indirect PE. Those costs are attributed to individual services and are captured in the direct inputs. We do not believe that those items increase indirect PE for a service but supplies and equipment are currently a significant component of the indirect PE allocation methodology. Similarly, the AGS believes that physician work in the facility setting (e.g., work RVUs for certain surgical procedures) is not relevant to allocating indirect PE. Indirect costs associated with such services are paid by the facility where the service is furnished and not by the physician performing the service; the indirect costs are reflected in the payment to the facility, and it is inappropriate to incorporate indirect costs for those services as part of the physician payment. However, physician work (or physician time) in the office, may be an appropriate allocator of indirect PE. We also believe that clinical labor is strongly associated with indirect PE, since additional staff are associated with costs included in the indirect PE estimate, such as office rent and administrative costs.

**Therefore, we ask CMS to stop allocating indirect PE using (1) disposable supplies, (2) equipment, and (3) physician work in the facility setting. We recommend that CMS continue to allocate indirect PE using clinical staff time.**

### III. Rebasing and Revising the Medicare Economic Index (MEI)

CMS proposes to update the weights for the components of the MEI using 2017 data derived predominantly from the U.S. Census Bureau's Service Annual Survey (SAS). This data would replace data from the AMA Physician Practice Information Survey (PPIS) and significantly change the weights assigned to all three components: physician work, PE, and malpractice. The table below shows the current and proposed weights.

	Current	Proposed
Physician Work	50.9%	47.3%
Practice Expense	44.8%	51.3%
Malpractice	4.3%	1.4%

CMS asks for comment about this proposal as well as about future adoption of the same weights in the rate-setting methodology for the PFS. CMS indicates that use of the weights in rate-setting will dramatically redistribute payments under the PFS to the disadvantage of primary care specialties including geriatrics. The specialties that are expected to benefit the most are non-physician entities such as portable x-ray suppliers, independent labs, and diagnostic testing facilities.

The AGS agrees with CMS that the data currently used in the MEI calculation should be updated. The updated data should accurately capture the costs involved in operating a physician practice. We share the AMA's concerns that there are significant limitations in the Census Bureau data because the SAS was not designed to capture the information necessary to update the MEI. CMS has not been able to sufficiently compensate for those limitations and the weights resulting from use of that the SAS data would inappropriately shift payment from physician work to PE. **Therefore, the AGS urges CMS to adopt the AMA's recommendation to pause consideration of alternative data sources, including the SAS, for**

**use in the MEI and to work with the AMA to ensure that data on PE costs are captured accurately and consistently across specialties.**

#### **IV. Potentially Underutilized Services**

CMS requests comments on ways to identify potentially underutilized services which it defines as services that support beneficiaries in promoting health and well-being and that may also reduce unnecessary spending by decreasing the need for more expensive care. CMS identifies certain primary care, preventive and screening, and patient education services as potentially underutilized and asks for ways to mitigate obstacles to accessing such services.

The AGS agrees with CMS that the potentially underutilized services, particularly the Annual Wellness Visits (AWVs), complex/chronic care management, cognitive assessment and care, and immunizations and vaccinations, are high value services that more Medicare beneficiaries should be receiving. A recently published article in the *Journal of the American Geriatrics Society (JAGS)*, Medicare's Annual Wellness Visit: 10 years of opportunities gained and lost,<sup>2</sup> explores strategies and interventions that may improve how to meet the wellness needs of older adults. Medicare AWV that address disease prevention and the promotion of health and wellness are important components of care for older adults. However, as noted by the authors, there is room to improve the impact AWVs have on the overall quality of care older adults receive.

We applaud CMS for proactively considering ways to improve utilization of these services and recommend that CMS consider steps to incentivize provision of the services as well as ways to reduce obstacles to furnishing or receiving this type of care. As an example, the Geriatric Interprofessional Team Transformation – Primary Care (GITT-PC)<sup>3</sup> is a program that focuses on a workforce culture change to empower primary care teams to achieve best practice in geriatrics in primary care. The GITT-PC found that a learning collaborative model, which involves monthly data collection and learning sessions, considerably increased the number of AWVs compared to other types of initiatives. We urge CMS to explore ways to support this type of transformative change.

CMS could also incorporate use of high-value services into quality metrics for value-based payment (e.g., Medicare Shared Savings) and Medicare Advantage, especially as most beneficiaries will be participants in such programs. For example, Part D plans have incentives for comprehensive medication reviews. AWVs, cognitive assessment and care planning, and other similar services could be similarly promoted.

Finally, we urge CMS to review and consider successful models or innovations. A recent [article in the \*Journal of the American Geriatrics Society\*](#) explored the common components of models of care in geriatrics when caring for older adults with care complexity.<sup>4</sup> The article defines care complexity in older

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<sup>2</sup> Coll PP, Batsis JA, Friedman SM, Flaherty E. Medicare's annual wellness visit: 10 years of opportunities gained and lost. *J Am Geriatr Soc*. Published online August 17, 2022. [doi:10.1111/jgs.18007](https://doi.org/10.1111/jgs.18007)

<sup>3</sup> Bartels SJ, Flaherty E, Tumosa N. The New Geriatric Interprofessional Team Transformation in Primary Care: An Implementation Science Approach. *Innovation in Aging*. 2018;2(1):30. [doi:10.1093/geroni/igy023.114](https://doi.org/10.1093/geroni/igy023.114)

<sup>4</sup> McNabney, MK, Green, AR, Burke, M, et al. Complexities of care: Common components of models of care in geriatrics. *J Am Geriatr Soc*. 2022;70(7):1960-1972. [doi:10.1111/jgs.17811](https://doi.org/10.1111/jgs.17811)

adults, reviews healthcare models and the most common components within the models, and identifies potential gaps that require attention to reduce the burden of care complexity in older adults.

## V. Evaluation and Management Services

### A. Other E/M Visits

CMS proposes to adopt the revisions to the other Evaluation and Management (E/M) visit code families for inpatient/observation, emergency department (ED), nursing facility, domiciliary/rest home, and home visits, with the exception of the prolonged services codes. CMS also proposes to accept the work and direct input recommendations from the RVS Update committee (RUC) for these codes. In addition, for the cognitive assessment and care planning code (99483), CMS did not accept the RUC work recommendation of 3.50 RVUs, which would have been a decrease from the current value of 3.80. Instead, CMS proposed a slight increase in the work RVUs for 99483 to 3.84 to preserve the rank order with the analogous outpatient/office (O/O) E/M service (99205) and to support access to this service. **The AGS agrees with these proposals, except those related to prolonged services, and urges CMS to finalize them as proposed.**

#### (1) Nursing Facility Codes

CMS raised specific questions about elements of the RUC recommendations for the nursing facility codes. **The AGS supports the explanations provided by the RUC in their comment letter and emphasizes the following points.**

*For 99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded,* the RUC recommended an increase in the work RVUs from 3.06 to 3.50. CMS noted that the total time assumed for the service did not change and questioned the recommended increase in RVUs. While total time is unchanged, time has shifted from post-service to intraservice. As a result, the intensity of the service has increased which supports the increased work RVU. CMS also asked for clarification regarding the use of Current Procedural Terminology (CPT) code 99205 as the key reference service to support the recommendations for CPT code 99306. The difference in total time between the two codes is only eight minutes (88 minutes for 99205 compared to 80 minutes for 99306) and 86 percent of the survey respondents rated 99306 as more or much more intense than 99205. Compelling evidence was presented showing a changing patient population for 99306 that is more complex and supports a work value at least equal to 99205. Additionally, the recommended value for 99306 provides consistency of intraservice work per unit of time (IWPUT) within the nursing facility codes.

CMS asked for clarification of the difference between the codes for initial nursing facility care (99306) and subsequent nursing facility care (99310) because the codes have almost identical descriptors including the length of time. Initial care is inherently more complex and requires more work than subsequent patient care. While the descriptors list the same times, the surveyed total time is 10 minutes longer for 99306 and surveyed intra-service time is five minutes longer. Even when codes for initial and subsequent visits have similar time, a rank order anomaly would be created if the initial visit was not assigned a higher work RVU than the subsequent visit.

CMS asked for comment on the RUC recommendation that the total time for 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, 15 minutes must be met or exceeded*, be rounded down to 15 minutes rather than up to 20 minutes when using total time on the date of the encounter for code selection. The RUC recommended rounding down to 15 minutes to maintain a 15-minute incremental pattern for subsequent nursing facility visit codes (15 minutes, 30 minutes, 45 minutes) to facilitate reporting of the services based on time. This will facilitate accurate coding and be easier for physicians to remember.

**Again, the AGS urges CMS to adopt the RUC recommended values for the nursing facility codes as proposed.**

(2) Prolonged Services

We disagree with CMS's proposal for prolonged services. Rather than recognizing the CPT codes, CMS proposes to adopt three new healthcare common procedure coding system (HCPCS) G-codes to describe prolonged services for hospital inpatient and observation care (GXXX1), nursing facility care (GXXX2), and home or residential care (GXXX3). CMS takes this approach because the agency disagrees with CPT guidance about the point at which the prolonged services code should apply. CPT allows for reporting of a prolonged services code 15 minutes after the time referenced in the descriptor of the base service code. For example, the unit of time in the descriptor for an initial hospital service with high decision making (99223) is 75 minutes and the CPT instructions would allow billing the prolonged services add-on code after 90 minutes. Instead of adopting this approach, CMS proposed that the prolonged services period begins 15 minutes after the total time on the date of the encounter for the base service code (as established in the Physician Time File and rounded to the nearest 5 minutes) has been met. CMS also proposed that the full 15-minute increment from that starting threshold must be completed in order to report the prolonged services code. Under this approach, a practitioner could only bill for a prolonged service for 99223 after 105 minutes (75 minutes base time + 15 minutes to the start of the prolonged services period + 15 minutes of prolonged services time).

The AGS strongly disagrees with this approach. As proposed by CMS, practitioners would receive no payment at all for additional time of less than 30 minutes beyond the highest-level visit threshold time. The proposal follows the similar approach that CMS took towards billing for the O/O E/M prolonged services. To support correct coding, the O/O codes had time ranges, with the upper boundary of the range marking the transition to the time at which a prolonged services could be reported and not for the time at which a prolonged service started. The timeframes for reporting prolonged O/O services were consistent with the CMS stated objective to provide for a lower threshold for the prolonged services code.

The insertion of a 15-minute gap makes prolonged services reported at 30 minutes, just as was the case for 99354 and 99356. 99354 and 99356 may be reported at 30 minutes past the typical time today. The manner in which CMS handles 99417 and 993X0 results in them not being reported until 29 and 30 minutes past the threshold time in CPT, which is the typical time. It is unclear why under this framework, CMS believes that extended care beyond the typical time for the highest-level code should routinely go unpaid. We recommend that CMS adopt the revised CPT codes for prolonged services (993X0, 99417) and not finalize the proposed codes GXXX1, GXXX2, and GXXX3.

Using a different methodology CMS proposes to disallow the use of 99417 for home/residence services and 993X0 for nursing facility services. Here, the logic is more confusing and the consequences more adverse and counter to relativity principles. For example, CMS proposes to allow GXXX3 at 141 and 112 minutes when 99345 or 99350, respectively, are the base codes. The surveyed time period for these codes is three days before the visit through seven days after the visit. In determining the start of a prolonged service, CMS uses the total time for the service period and not the time on the date of the encounter. Further, CMS is unclear if the additional time must occur on the date of the encounter or is over the span of three days prior to seven days after the date of the encounter. If the pre and post time which CMS has added to the base code descriptor time must be incurred on the date of the encounter before prolonged services may be reported, CMS must be working under the supposition that no pre and post time would occur in the extended window of three days prior and seven days after the visit. Otherwise, CMS is not accounting for the pre and post work of the typical service. It is highly implausible that the typical 99345 or 99350 would not have pre and post time and work performed. If instead, CMS proposes that the prolonged service determination is based on the total time over an 11-day span, the practicality of submitting claims under this approach represents an extreme administrative burden. Practitioners would need to count total time over the 11-day period and hold each claim until the period has elapsed. Furthermore, if it is based on time on the date of the encounter and presuming the typical pre and post work would occur for a service that requires prolonged time on the date of the encounter, CMS expects practitioners to forego payment for 50 minutes of time related to new patients and 36 minutes of time for established patients. This approach would be particularly detrimental to practitioners who care for the most vulnerable community residing beneficiaries. Given that access is already a problem for these beneficiaries, the inconsistency of CMS's proposal is puzzling. CMS used a similar flawed methodology for GXXX2. **We strongly recommend that CMS not finalize GXXX2 and GXXX3 and allow prolonged nursing facility and home/residence visits to be reported using 993X0 and 99417, respectively.**

Equally astonishing is the proposed technical correction regarding critical care. CMS proposes to rewrite the coding rules for 99291 and 99292 and limit reporting of additional critical care time due to a reading of the descriptors that conflicts with the longstanding interpretation. These codes have very clear instructions and time ranges in a table in the CPT manual that has been well understood by practitioners, coders, and regulators for more than 20 years. The last valuation of these services was based upon these longstanding well-understood rules and is inconsistent with the technical correction proposed by CMS. We believe this proposal further illustrates confusion over time ranges, a confusion that first became apparent when CMS reversed the 2020 PFS decision to accept the office or other outpatient times and prolonged service times, revised the timetable published in the 2020 final rule, and created a G-code in the NPRM for 2021. We believe these proposals and the current requirement to use G2212 to report prolonged O/O E/M services reflect a misunderstanding of the valuation process, confusion over coding guidance (despite clear tables in CPT), and inconsistencies in reporting requirements that are neither resource based nor sound policy. Instead, the cardinal goal of the E/M revisions, reducing administrative burdens, is thwarted with prolonged services requirements that increase administrative burden. If CMS does not adopt the CPT codes and rules for prolonged services and chooses to finalize the G-codes for other reasons, it should not apply the proposed payment methodology. CMS should instead allow for reporting of the prolonged services code 15 minutes after the threshold total time on the date of the encounter in the descriptor for the base code.

Finally, while we appreciate the recognition of the proper relativity for 99483, **we do not understand why CMS proposed that prolonged services codes cannot be reported with cognitive assessment and care planning services.** Since the inception of the code, prolonged services have been

allowed. If 99483 cannot be reported as a prolonged service, the practitioner may have incentives to instead use time and report it as 99205. The stated CMS rationale is that a “typical” time is in the descriptor. Typical time has a long history of use in E/M and prolonged E/M. The most recent revision to 99483 only related to the time for the purposes of reporting prolonged services. Had this concern about typical time been raised during the CPT process, CPT could have easily written the code so that prolonged services could only be reported when a specific time was exceeded. For example, stating “(the required time of 99483 for the purposes of reporting 99417 is 60 minutes, 99417 may be reported at 75 minutes)” which would have articulated what was understood by CPT, the RUC, and practitioners.

We appreciate the extensive support CMS has given to care management services; however, not all patients or practices meet the requirements for these services. **We believe there remains a role for 99358 and 99359, Prolonged Services without direct contact.** Examples of uses include extensive surgical planning; time spent in conjunction with the primary treatment team, without a face to face visit, on a date after an inpatient consultation service (e.g., after 99223, where there is no post service time); and care transitions work when the primary care practitioner was not notified of the discharge in time to report transitional care management or the patient did not require an in-person visit, yet there was extensive record review and patient management. These services may not be reported on the date of an E/M in CPT 2023 and the time must be performed on a single date. If CMS is concerned about overlap based upon a RUC survey methodology that included up to 15 minutes post service time over seven days after an office service or up to 10 minutes pre-service time over three days for established office patients, it may be better to define the allowed reporting window than to make these services “invalid.” This will be especially important after the end of the public health emergency (PHE) when coverage of audio-video and audio-only office visits will be severely limited.

**In summary, we recommend that CMS:**

- **Not finalize the proposed G-codes to describe prolonged services;**
- **Recognize 99417, 993X0, 99358, and 99359 and adopt the RUC recommended RVUs and inputs for these codes; and**
- **Adopt the CPT guidance for reporting prolonged services.**

(3) Nursing Home Admission Services on the Same Date as Other E/M Services

We note that CMS disagrees with the CPT guidelines that permit two E/M services to be reported on the same date. We note that CMS has long allowed the same practitioner to report hospital inpatient discharge services and initial nursing facility services on the same date. The Medicare Claims Processing Manual states: “A/B MACs (B) pay the hospital discharge code (codes 99238 or 99239) in addition to a nursing facility admission code when they are billed by the same physician with the same date of service.”<sup>5</sup> This is generally an infrequent event and we do not believe CMS intends to reverse this policy. It is particularly important that the initial encounter by the attending physician be separately reported because the required comprehensive assessment is distinct from E/M in the other settings of care, especially the discharge service. The current policy supports care continuity and higher quality nursing facility care.

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<sup>5</sup> Medicare Claims Processing Manual, Chapter 12, Section 30.6.9(D).



CMS also proposes to disallow reporting of ED visits on the same day as comprehensive nursing facility assessments even when those services are furnished by two different practitioners. This is inappropriate and appears to be a misunderstanding of the current policy. CMS states, “We note that the Medicare Claims Processing Manual also states that ED visits provided on the same day as a comprehensive nursing facility assessment are not paid, regardless of whether the ED and nursing facility visits are by the same or different practitioners (emphasis added). We are proposing to retain this policy as well.” The underlined language is not included in the manual provision on ED services and nursing facility admission which reads:

Emergency department visit provided on the same day as a comprehensive nursing facility assessment are not paid. Payment for evaluation and management services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.<sup>6</sup>

The manual language is clearly intended to preclude a practitioner who has seen the patient in the ED from also billing for the nursing facility assessment when performed on the same date of service. There is no indication that services furnished by a separate practitioner in a different setting should not be reported on the same date of service. Other manual provisions related to billing for nursing facility admission services make it clear that any restrictions are specific to certain practitioners and do not apply to all services. For example, in the same manual section that explicitly allows for reporting of hospital discharge services on the same day as the nursing facility admission service, there is a provision that restricts billing of the nursing facility admission “by a surgeon in the postoperative period of a procedure with a global surgical period if the patient’s admission to the nursing facility is to receive post operative care related to the surgery”<sup>7</sup> but allows the surgeon to furnish the nursing facility admission service if the admission is unrelated to the surgery. Clearly the manual intends to avoid potentially duplicative payment to an individual practitioner but not to preclude a beneficiary from receiving needed care by another practitioner.

The basis for the proposed policy is inexplicable. While a skilled nursing facility (SNF) payment may include certain services, professional payments are excluded. This policy could be an impediment to appropriate clinical care and further incentivize practitioners to simply refer patients to the ED rather than risk nonpayment because their claim processed after the ED physician claim. It would be equally unfair to expect the ED practitioner to provide a free service because a wholly unrelated clinician also saw the patient that day. **We recommend that CMS maintain its current policies and allow reporting of nursing home admission services on the same day as hospital discharge services furnished by the same or different practitioner and on the same day as emergency department services when furnished by different practitioners.**

## **B. Specialty Classification for Non-Physician Practitioners (NPPs)**

In defining “initial” and “subsequent” E/M services, CMS proposed that an initial service is when a “patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay.” A subsequent service is one when a patient has

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<sup>6</sup> Medicare Claims Processing Manual, Chapter 12, Section 30.6.11(D).

<sup>7</sup> Medicare Claims Processing Manual, Chapter 12, Section 30.6.9(D).

received such services during the stay. CMS proposed to maintain its current policy that advanced practice nurses and physician assistants working with physicians are always classified in a different specialty than the physician but indicated that it is considering whether this provider taxonomy aligns with clinical practice. Specifically, CMS indicated it might in the future consider NPPs as working in the same specialty as the physicians with whom they work.

We urge CMS to propose this change to the provider taxonomy. Currently NPPs are considered a separate specialty from the physician with which they practice. Under this taxonomy, NPPs who work with specialty physicians may appear to be primary care practitioners rather than specialists which can distort beneficiary assignment for Accountable Care Organizations (ACOs) and “leakage rates” in Primary Care First. To avoid this situation, **we recommend that CMS revise the taxonomy codes to provide more granularity and differentiate between NPPs who are working in primary care, behavioral health, and those working in specialty practices.**

### **C. Visit Complexity**

In discussing the revised Other E/M codes, CMS notes that in some cases the RUC appears to assume that patient needs were inherently more complex, or work was more intense for E/M visits in a non-office setting. CMS disagrees with this assumption and notes, for example, that additional staff and resources are typically available in a non-office setting and therefore it may be more challenging to coordinate and gather the same type of care and information in the office setting. The AGS agrees that services furnished in the facility setting are not inherently more complicated than E/M services furnished in the office setting.

CMS does not make any proposals in this rule related to the add-on code for visit complexity (G2211) that was originally intended to be implemented in 2021 but indicates that it still intends to implement this code. Implementation was delayed by Congress until at least January 1, 2024. The AGS believes that the delay provides an opportunity for CMS to refine the descriptor for G2211 and develop additional guidance as to how it should be used in order to ensure that the additional payment is targeted to services that involve additional complexity. We believe that such refinement will both ensure that the additional money is spent on services that actually reflect higher complexity and will reduce the impact of utilization of the add-on code on the conversion factor.

We believe that G2211 is meant to describe additional complexity that is part of visits that require a care team and is related to how the team prepares for, executes, finishes, and follows up on the visit and reflects the substantial coordination and collaboration among care team members to prepare for, furnish, and follow-up on a visit. The obligation of longitudinal care creates a greater level of work at the encounter and during the inter-encounter interval. These types of visits may be part of caring for a multimorbid complex patient or a patient with a single serious condition, such as diabetes, that requires complicated visits involving multiple care team members. These types of visits could occur in the physician office setting or the patient’s home. We do not believe that G2211 should be used for management of an acute condition (e.g., pneumonia) unless the patient is also being followed longitudinally for a chronic condition. The AGS does not believe that visits involving straightforward or low Medical Decision Making (MDM) involve the type of complexity described by G2211. CMS should allow reporting of G2211 with the home or residence visit codes that involve moderate or high MDM. We also believe that primary care teams have greater care coordination requirements than other practitioners and therefore perform work that is not recognized. This work would not typically meet all

the requirements to report chronic care management or principal care management codes in most cases but is relevant for patients that have required at least moderate MDM in the encounter.

We do not believe that CMS intends for G2211 to be appended to all E/M visits; however, it is not clear how to identify those services that are truly more complex. Therefore, we recommend that CMS request comment in this final rule on the following potential clarifications:

- Whether G2211 should only be used in connection with office or home visits where the health professional is following the patient longitudinally for one or more chronic conditions;
- Whether the patient relationship codes can be used to identify which practitioners should be reporting G2211;
- Whether G2211 should NOT be used for visits where the primary condition is acute UNLESS the health professional is ALSO following the patient longitudinally for chronic conditions; and
- Whether G2211 should only be used in conjunction with services requiring MDM of moderate (99204, 99214, 99344, 99349) or high (99205, 99215, 99345, 99350) levels.

We also recommend that CMS consider revising the descriptor for G2211 to better reflect the universe of services for which the complexity code should be reported.

Because of the potential impact of G2211 on total spending and therefore on the rates paid for all services under the PFS, **we strongly recommend that CMS include a comment solicitation on these issues in the final rule to provide CMS with additional input in preparation for making a proposal on the descriptor for G2211 and when it can be used in its rulemaking for 2024.**

#### **D. Split (or Shared) Visits**

In rulemaking for 2022, CMS finalized a change in how practitioners who split or share a visit determine who provides the substantive portion of the service and should therefore bill for the services. Beginning January 1, 2023, the substantive portion of a split (or shared) visit will be determined based solely on time and will no longer allow the substantive portion to be determined based on MDM. In this rule, CMS proposes to delay implementation of this change until January 1, 2024.

The AGS strongly disagrees that the substantive portion should be determined based solely on time. MDM, which is the most important part of any E/M visit, should be an option for determining the substantive portion of a service and the clinician who performed the MDM should be able to bill for the service. Billing shared visits based on time alone will disincentivize team-based care and result in an inefficient allocation of physician and NPP resources. In almost all cases, the reporting clinician will be the NPP which is inappropriate when the physician performs the MDM.

**The AGS recommends that CMS reverse its policy change and allow a split visit to continue to be billed based on EITHER time OR MDM, which is the policy in 2022.** Unless documentation in the medical record clearly indicates that the physician spent the majority of time or was responsible for the MDM, the visit should be billed by the non-physician. The AGS believes this policy is clear and could be easily audited. **If CMS does not reverse the policy change, then we support delaying implementation until January 1, 2024, at the earliest.**

**We also recommend that CMS extend its shared visit policy to certain home visits.** When the nurse practitioner sees the patient in the patient’s home and the physician performs the MDM, CMS should allow this service to be reported as a shared visit. “Incident to” policies do not apply to home visits and the concept of a shared home visit is identical to that of a shared facility visit. CMS also currently does not allow split (or shared) nursing facility services at the nursing facility level (as compared to skilled nursing facility level). While we understand that regulations require certain visits be performed by the physician, not all nursing facility level visits are in this category. A long-term care nursing facility resident with acute needs may well be seen by an advanced practice nurse who in conjunction with the physician determine the care or MDM.

**We also previously wrote and reiterate that we hope CMS will support team-based care by allowing incident-to services for new patients and new problems.** Such a change would recognize that the care model has evolved and that new patients, or established patients with new problems, are managed jointly by physicians and NPPs. It would be reasonable to require that the new patient care plan being implemented “incident to” was jointly created with the physician even if on the date of the encounter (i.e., it would be incident to the plan that was present, revised, or created on the date of the visit).

## **VI. Immunization Administration**

CMS proposes to adopt the RUC recommendations, with minor revisions, for the immunization administration codes (90460, 90461, 90471 - 90474). This approach will increase payment for the initial administration codes, 90460 and 90471, from \$16.96 in 2022 to \$21.50 and \$19.18, respectively, in 2023. **The AGS agrees that appropriate payment is necessary to ensure access to these critically important services and urges CMS to finalize the RVUs as proposed.**

The AGS also urges CMS to consider additional steps that could be taken to promote access to preventive vaccines. We believe that the additional payment for the provision of the COVID-19 vaccine to beneficiaries in their home has expanded access to that vaccine. **We urge CMS to consider extending the additional payment for vaccines administered in the home after the end of the PHE and expanding the availability of additional payment to the other preventive vaccines covered under Medicare furnished in the home.**

**We also ask CMS to consider creating a G-code to describe vaccine counseling that does not result in administration of the vaccine.** Doing so would align CMS payment policy with the National Vaccine Advisory Committee (NVAC) Standards for Adult Immunization Practice (SAIP).<sup>8</sup> It would also reflect that for many vaccines that are not covered under Part B (e.g., recombinant zoster), the clinician will counsel and refer elsewhere for vaccination in order to access Part D coverage. Furthermore, research has highlighted the important role that primary care clinicians (internal medicine, family medicine, geriatrics, pediatrics) play in the delivery of vaccinations to the US population.<sup>9,10</sup> In addition,

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<sup>8</sup> Centers for Disease Control and Prevention (CDC). Standards for Adult Immunization Practice. Updated May 2, 2016. Accessed August 25, 2022. <https://www.cdc.gov/vaccines/hcp/adults/for-practice/standards/index.html>.

<sup>9</sup> Wilkinson E, Jetty A, Petterson S, Jabbarpour Y, Westfall JM. Primary Care’s Historic Role in Vaccination and Potential Role in COVID-19 Immunization Programs. *Ann Fam Med*. 2021;19(4):351-355. [doi:10.1370/afm.2679](https://doi.org/10.1370/afm.2679)

<sup>10</sup> Mohanty S, Carroll-Scott A, Wheeler M, et al. Vaccine Hesitancy in Pediatric Primary Care Practices. *Qual Health Res*. 2018;28(13):2071-2080. [doi:10.1177/1049732318782164](https://doi.org/10.1177/1049732318782164)

the COVID-19 pandemic has heightened vaccine hesitancy and counseling provided without vaccine administration can involve as much or more clinical work than counseling that results in a vaccination.

The AGS believes that counseling is essential to address patients' questions and concerns regarding vaccines in order to overcome this hesitancy and ensure that as many patients as possible receive appropriate preventive care. However, the vaccine administration may not occur at the same time or site as the counseling and a G-code would allow health care practitioners to appropriately report the counseling service. This code should not be limited in terms of the number of times it can be billed given the ongoing need for clinicians to assess the patient's vaccination status, as recommended under the SAIP, to determine whether recommended vaccinations were received as well as the likelihood that additional counseling may be necessary in cases of vaccine hesitancy. Vaccine counseling is not always one and done. It is often a process over time, and we should be incentivizing repeated counseling by a trusted health care professional with whom the patient has a longitudinal relationship. Additionally, our members have noted that talking about counseling for one vaccine invariably leads to questions about other vaccines. While the patient refuses one type of vaccine, they may accept another and this would not happen without counseling.

Finally, as noted above, health care professionals, practices, and health systems are excluded from receiving payment for the Tetanus, Diphtheria, Pertussis (Tdap) and recombinant zoster vaccines under Medicare Part B; as a result, most beneficiaries receive these immunizations in the pharmacy setting. Physicians are considered out of network for Part D plans, making it difficult for them to ascertain coverage information and adding to the financial burden of offering vaccination in the clinician office. The Medicare Payment Advisory Commission (MedPAC) has recommended that all vaccines be covered under Part B since physicians and pharmacists are both allowed to bill for vaccines under Part B. **The AGS encourages CMS to reimburse all entities providing all vaccinations recommended for older adults** so that the entities may administer these vaccines for their patients outside the pharmacy setting, increasing the accessibility for this population.

## **VII. Audio-Only Communications and Other Telemedicine**

During the PHE, CMS has considered the telephone E/M services (99441 - 99443) to be a replacement for in-person E/M services. CMS added those codes to the Medicare Telehealth Services List and pays them at the same rate as an in-person E/M services for the duration of the PHE. CMS has also created codes to describe virtual check-in services of 5-10 minutes (G2251) and 11-20 minutes (G2252) that can be used to report audio-only services and has valued those based on RVUs for the comparable telephone E/M service codes, which is considerably lower than the rate paid for the telephone E/M services during the PHE.

CMS has received requests to add 99441 - 99443 to the Medicare Telehealth Services List on a Category 3 basis but did not propose to make this change for 2023. As a result, these codes will no longer be considered Medicare telehealth services 151 days after the end of the PHE. At that time, the codes will no longer be separately payable.

The AGS believes that audio-only E/M services are important tools for caring for certain patients, particularly older patients and patients who are low income, both of whom may not have access to more advanced audio-visual technology such as smart phones or computers. We note that audio-only E/M services are not simple phone calls directing the patient to schedule an in-person visit but can often involve prolonged conversations and evaluation. **The AGS recommends that CMS continue paying for**

audio-only services after the end of the PHE and that CMS create a new code for audio-only communication that lasts from 20-30 minutes. The AGS also recommends that CMS revisit the payment for these services to make sure they appropriately reflect the physician work and PE associated with these services.

During the PHE, CMS suspended frequency limitations for telemedicine in the skilled nursing facility and nursing facility services. Medically necessary care should not be arbitrarily limited so long as the required in-person services are provided after the end of the PHE. **We ask that CMS not reinstitute clinically irrelevant frequency limitations on telemedicine services.**

CMS, in accordance with statute, will allow telemedicine services in behavioral health and substance use disorder (SUD) treatment, indefinitely. **We urge CMS to further prepare for this by publishing proposed guidance on implementation.** We believe audio-only services and E/M codes are included, not just psychiatric services codes. We do not believe provider taxonomy determines eligibility as many services are provided by primary care and individuals who have dedicated their careers to better SUD care, but who are general internists or family physicians. Additionally, the advance practice nurses and physician assistants taxonomies are inadequate to distinguish the type of practice. If this will be diagnosis (ICD-10) driven, it will help to know whether the relevant code must be the primary diagnosis or other conditions will be considered. Finally, will dementia (e.g., Alzheimer’s Disease and related disorders) be included, or only if problematic behavioral manifestations are present? **Therefore, we recommend that CMS make clear in the final rule that telemedicine services furnished in connection with behavioral health and SUD treatment can be performed by any physician specialty and appropriately trained and licensed NPPs. We also recommend that CMS clarify how a behavioral health or SUD telemedicine visit will be defined (e.g., by diagnosis code) and services furnished to patients with dementia and related disorders because it is typical for those patients to have mood or other behavioral symptoms and sequelae.**

#### **VIII. Chronic Pain Management and Treatment Bundles**

CMS proposes to introduce two new codes to describe services for chronic pain management (CPM) and treatment in an effort improve the care experience of individuals with chronic pain. CMS proposes to define chronic pain in this context as “persistent or recurrent pain lasting longer than three months.” **The AGS agrees that the CPM service is distinct from the service described by other care management codes and CMS should create a code for CPM services.** There is currently no CPT or HCPCS code available to describe such services and activities that CMS identifies as being part of this service, including development and maintenance of a person-centered care plan and facilitation, crisis care, and coordination of any needed behavioral health treatment, and are not well-recognized by other codes. **If CMS identifies specialties that can or are expected to furnish this service, we ask that CMS include geriatrics as one of those specialties.**

CMS proposes to create two G-codes to describe monthly CPM services:

- HCPCS code GYYY1: *Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain*

- related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care (e.g. physical therapy and occupational therapy, and community-based care), as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using GYYY1, 30 minutes must be met or exceeded.)*
- HCPCS code GYYY2: *Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month (List separately in addition to code for GYYY1). (When using GYYY2, 15 minutes must be met or exceeded.)*

The AGS appreciates that CMS has included medication management in the descriptor for GYYY1. Careful evaluation of all pain management medication, including consideration of the AGS Beers Criteria<sup>®</sup> regarding potentially inappropriate medications for use in older adults, should be included as part of the CPM service. **We urge CMS to keep the element of medication management in the descriptor finalized for this code.**

We believe that other elements of the descriptor for GYYY1 may need further refinement. Statements in the rule indicate that CMS intends to require that an initial visit for CPM be face-to-face but not require a face-to-face visit for subsequent care.<sup>11</sup> However, as proposed, the descriptor appears to require an initial face-to-face visit each month. **We recommend that CMS clarify the frequency and timing of the face-to-face visit requirement and revise the descriptor accordingly. We also ask CMS to create a code to report CPM services that are furnished by clinical staff similar to the clinical staff codes for other care management services.**

Possible code revision follows:

- HCPCS code GYYY1: *Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care (e.g. physical therapy and occupational therapy, and community-based care), as appropriate. ~~Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; Required initial face-to-face visit at least 30 minutes personally provided by physician or other qualified health care professional, per calendar month.~~ (When using GYYY1, 30 minutes must be met or exceeded.)*
- HCPCS code GYYY1A: First 30 minutes personally provided by physician or qualified health in a month subsequent to the required initial face-to-face evaluation, per calendar month (When using GYYY1A, 30 minutes must be met or exceeded.)
- HCPCS code GYYY2: *Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month (List separately*

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<sup>11</sup> “After consultation with our medical officers, we believe the management of a new patient with chronic pain would involve an initial face-to-face visit of at least 30 minutes due to the complexity involved with the initial assessment. We believe follow-up or subsequent visits could be non-face to face.” 87 Fed. Reg. 45935

*in addition to code for GYYY1 or GYYY1A). (When using GYYY2, 15 minutes must be met or exceeded.)*

#### **IX. Caregiver Behavior Management Training (CPT codes 96X70 and 96X71)**

The AGS strongly disagrees with CMS’s proposal not to recognize new CPT codes that describe training of caregivers on behavior management/modification (96X70 and 96X71). The training described by these codes is an important element of patient-centered care and better prepares caregivers to implement necessary elements of care plans. The services are for patients with mental or physical health diagnoses and intended to address the treatment needs of the patient’s illness.

However, because the training is furnished to caregivers without the patient present, CMS believes that the Medicare statute precludes coverage of the service. We disagree. The services are directed to caregivers of patients diagnosed with an illness and intended to provide technical skills to reduce the impact of the diagnosis on the patient’s daily life. Caregiver training services clearly benefit the patient. These services enable caregivers to better address the patient’s needs and provide assistance to perform activities of daily living, understand the risks of falling, and avoid emergency room visits. Not paying for these services is also a health equity issue because in many cases the patients at issue have dementia and other disorders that place them at great social and economic disadvantage.

The AGS strongly believes that the training meets the statutory coverage requirement that services must be “reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve the function of a malformed body member”<sup>12</sup> of an individual Medicare beneficiary. If CMS is only willing to pay for these services when the patient gives permission or is notified that a caregiver training service is to be furnished, then we support such a requirement as long as it is not burdensome and can be waived in the case of patients with moderate to severe dementia.

Appropriate caregiver training is an important element of well-coordinated care and can help reduce stress for patients and caregivers, improve patient outcomes and reduce the use of unnecessary services such as the ED. **We strongly recommend that CMS recognize 96X70 and 96X71 for payment by Medicare and adopt the RUC recommend inputs and work RVUs to value these services.**

#### **X. Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings**

CMS proposes to change the descriptors of codes for two annual screening services, G0442 (screening for alcohol misuse) and G0444 (screening for depression). The current descriptors require the services to last 15 minutes and CMS proposes to change the descriptors to describe services that range from 5 to 15 minutes. **The AGS agrees that these screening services may take less than 15 minutes and urges CMS to finalize the revised descriptors as proposed.**

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<sup>12</sup> Social Security Act 1862(a)(1)(A).



## **XI. Behavioral Health and Psychotherapy**

### **A. Revisions to the “Incident to” Physicians’ Services Regulation for Behavioral Health Services**

**The AGS recommends that CMS finalize the proposal to amend the “incident to” regulations to allow behavioral health services to be furnished by licensed clinical social works and licensed marriage and family therapists under the general supervision of a physician or other practitioner.** We agree with CMS about the need to improve access to behavioral health services and believe that this will help address those needs and workforce shortages in this field.

### **B. New Coding and Payment for General Behavioral Health Integration**

CMS proposes to create a new code (GBHI1) to describe general behavioral health integration performed by clinical psychologists or clinical social workers when the mental health services furnished by one of these professionals serve as the focal point of care integration. CMS proposes to value this code by crosswalking to the existing CPT code for care management for behavioral health conditions (99484). **The AGS supports the creation of GBHI1 under general supervision.**

**However, we disagree with the proposed valuation.** CPT code 99484 describes clinical staff time and is valued assuming the service is performed by a Behavioral Health Care Manager. Those assumptions do not accurately reflect the cost when the service is performed by a clinical psychologist or clinical social worker. **CMS should value this code to appropriately reflect the level of care provided. CMS should also clarify whether an initiating visit is required, and if so, list those services that meet this requirement.**

### **C. Change in Procedure Status for Family Psychotherapy**

CMS proposes to remove the restricted procedure status indicator for family psychotherapy codes (90847 and 90849). **The AGS appreciates CMS’s efforts to remove barriers to accessing needed behavioral health services and urges CMS to finalize this change. We also believe 90846 should not be restricted.** This is an important service particularly for adolescents, families of substance use disorder patients, and families attempting to manage behavioral manifestations of dementia. The treatment is directed to the patient and not therapy for the family member.

## **XII. Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order**

In response to requests of interested parties, CMS proposed to remove the requirement that a treating physician or other practitioner order certain hearing and balance assessments furnished personally by an audiologist for non-acute hearing conditions. These non-acute hearing conditions would not include balance assessments for patients with disequilibrium. CMS proposed to create a new HCPCS code to describe these services, “GAUDX (Audiology service(s) furnished personally by an audiologist without a physician/NPP order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids or examinations for the purpose of prescribing, fitting, or changing hearing aids; (service may be performed once every 12 months)).” The GAUDX code would include and be used to bill for any number of audiology services furnished in a particular encounter with a beneficiary. The actual tests provided and their results would need to be documented in the medical record. CMS would establish system edits which would ensure that GAUDX is paid only once every 12 months, per beneficiary. **While this service may not**

be valued based upon a single service, we believe it is acceptable to create a payment grouping until such time as more experience is gained.

The AGS supports the proposal and urges CMS to finalize it.

### XIII. Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services

The AGS appreciates CMS's request for input on codifying coverage related to medically necessary dental care. **We believe that improving oral health will improve health outcomes, health equity, and quality of life for older Americans.** In response to the CMS request for criteria to use in determination of medical necessity, we agree with the Santa Fe Group recommendation<sup>13</sup> that CMS should use the triple aim criteria for guidance in identifying dental services that should be covered. For example, CMS should consider coverage of dental problems and procedures that are inextricably linked to the clinical success of an otherwise covered medical service, and therefore, are substantially related and integral to that primary medical service. We also agree that covered dental services should improve one or more of the targets of the triple aim: patient experience, cost, and clinical outcomes. The AGS is concerned that adding dental services to the PFS without Congressional approval for a corresponding increase in spending will further strain an already stressed payment system. **We encourage the Biden Administration to work with Congress to ensure that funding sufficient to cover medically necessary dental care is approved in future Medicare budgets.**

### XIV. RFI: Medicare Part B Payment for Services Involving Community Health Workers

CMS requested information on whether and how community health workers, as auxiliary personnel of physicians or hospitals, may provide reasonable and necessary services to Medicare beneficiaries under the supervision of health care professionals who are responsible more broadly for medical care.

The AGS members include numerous types of practitioners—including geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician assistants, pharmacists, and internists—that often work in teams to care for our patients, who are among the frailest Medicare beneficiaries. Our members have found that community health workers can be an important part of those teams, particularly to help address loneliness, which can be the root cause of other symptoms such as pain, fatigue, and depression.<sup>14</sup> **We recommend that CMS consider ways to support the community health workers and enable Medicare beneficiaries to better access the services they furnish.**

### XV. Medical Necessity and Documentation Requirements for Nonemergency, Scheduled, Repetitive Ambulance Services

CMS proposes to modify existing regulations to add additional language to provide clarity and ensure consistent application of the nonemergency, scheduled, repetitive ambulance service benefit. Specifically, CMS proposes to clarify that a physician certification statement (PCS) and additional

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<sup>13</sup> Santa Fe Group. SFG Submits Letter to CMS in Support of Medically Necessary Dental Coverage. Published August 24, 2022. Accessed September 2, 2022. <https://santafegroup.org/news/medicare/sfg-submits-letter-to-cms-in-support-of-medically-necessary-dental-coverage/>.

<sup>14</sup> Powell VD, Kumar N, Galecki AT, et al. Bad company: Loneliness longitudinally predicts the symptom cluster of pain, fatigue, and depression in older adults. *J Am Geriatr Soc.* 2022;70(8):1-10. [doi:10.1111/jgs.17796](https://doi.org/10.1111/jgs.17796)

documentation from the beneficiary's medical record may be used to support a claim that transportation by ground ambulance is medically necessary; the PCS and additional documentation must provide detailed explanations consistent with the beneficiary's current medical condition to explain the beneficiary's need for transport by an ambulance; and that coverage includes observation or other services rendered by qualified ambulance personnel.

The AGS understands that the intent behind these provisions is to reduce inconsistency in payment for non-emergency ambulance services and reduce the potential for abuse. We support these goals, but we note that much of the work of fulfilling these requirements will not be performed by the ambulance suppliers and instead fall to the practitioner—most likely a primary care practitioner—who orders the service. **We ask CMS to be cognizant of the additional burden of such proposals and consider other ways that it can achieve these goals.**

## **XVI. Medicare Shared Savings Program (MSSP)**

The MSSP promotes many ideals of geriatrics care and MSSP organizations often recognize the leadership of geriatrics professionals and the need for an age-friendly system of care. Unfortunately, the Medicare fee schedule inadequately recognizes the value geriatrics healthcare professionals bring to the care of Medicare beneficiaries. Below we provide comments and recommendations regarding CMS's proposals with respect to the MSSP.

### **A. Health Equity Adjustment**

In alignment with its goals to have 100 percent of the Original Medicare beneficiaries in a care relationship by 2030 as well as to expand the reach of ACOs into rural and other underserved communities, CMS is proposing to create a health equity adjustment that would upwardly adjust quality performance scores for ACOs that serve a disproportionately high share of underserved individuals. CMS believes this upward adjustment would incentivize more ACOs to provide care to underserved populations and mitigate the negative impact of the transition to electronic clinical quality measures (eCQMS) on ACOs that are already serving such populations. While eCQMs are reported for all payers, including Medicaid, the measures reported through the CMS Web Interface have historically only included quality scores for Medicare beneficiaries. People with Medicaid have increased social risk factors compared to people with Medicare and patients with those risk factors tend to have worse quality scores. CMS proposes to use both the area deprivation index (ADI) and Medicare and Medicaid dually eligible status to identify ACOs serving larger proportions of underserved beneficiaries.

The AGS supports these goals and agrees with CMS about the importance of incentivizing ACOs to care for underserved populations. **We urge CMS to finalize the health equity adjustment** and monitor whether the adjustment achieves the goal of rewarding ACOs for high quality performance while caring for larger proportions of underserved beneficiaries.

### **B. Use of High Revenue Accountable Care Organization (ACO) Designation**

CMS defines a high revenue ACO as an ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO participants is at least 35 percent of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries.<sup>15</sup> High revenue ACOs are more likely to include

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<sup>15</sup> 42 C.F.R. 425.20.

hospitals while low revenue ACOs tend to be small, physician-only ACOs. CMS estimates that high-revenue ACOs are only 50 percent as effective as low-revenue ACOs at reducing spending because high-revenue ACOs include a more comprehensive mix of providers and the incentive to share in a fraction of the savings is weak compared to the immediate revenue from utilization.

Certain supports and incentives are not available to high revenue ACOs. For example, CMS proposes that new advance investment payments (AIPs), which are intended to reduce the financial barriers, to join MSSP and promote availability of MSSP in underserved communities that are not available to high revenue ACOs. If an ACO becomes a high revenue ACO while receiving AIPs, the AIPs would cease. CMS proposes to monitor and notify ACOs if they become high revenue during a performance year so the ACO can choose to modify its participant list for the next performance year to maintain their low revenue status.

The AGS questions the need for this proposal. CMS proposes other guardrails for the AIPs to ensure that they are limited to ACOs that are new to the MSSP program, including preventing renewing or re-entering ACOs from receiving AIPs and requiring that eligible ACOs be inexperienced with performance-based risk. Restricting access to AIPs for high revenue ACOs could lead ACOs to actively exclude high-cost providers and suppliers from their participant list which may limit the ACO's ability to manage care. In addition, the monitoring of high revenue status may be complicated and burdensome for both ACOs and CMS. Requiring ACOs to remove participants to avoid the high revenue designation would be disruptive to the organizations and could also undermine efforts to manage care. In addition, this proposal conflicts with other MSSP provisions. For example, CMS chooses not to prevent high revenue ACOs from being able to access additional flexibilities intended to keep ACOs in the MSSP program.

Despite their concerns about the track record of high revenue ACOs within the MSSP, CMS acknowledges that high revenue ACOs have a greater opportunity to control expenditures because they coordinate a larger portion of the care furnished to the beneficiaries. We believe that such organizations that are not currently participating in MSSP should have access to AIPs and other incentives to encourage participation. We feel this is particularly important to meet CMS's goals of expanding access to ACOs in underserved areas and retaining ACOs in MSSP. **The AGS urges CMS to remove barriers to participation in MSSP by high revenue ACOs by not finalizing the proposal to restrict access to AIPs and finalizing the proposal that they be eligible for the extended transition to performance-based risk.**

#### **C. Skilled Nursing Facility 3-Day Rule Waiver**

CMS proposes to replace the requirement for ACOs to submit certain narratives when applying for a waiver to the SNF 3-day rule with an attestation that the narratives have been established and can be made available to CMS upon request. **The AGS supports efforts to reduce the administrative requirements on ACOs, particularly requirements related to the 3-day rule, which can complicate the ability of beneficiaries to access care in the most appropriate setting.** We urge CMS to finalize this proposal.

#### **D. Determining Beneficiary Assignment**

CMS lists CPT and HCPCS codes for primary care services that may be used for beneficiary assignment or attribution. We believe certain codes are frequently used by specialists and therefore have

a high probability of creating incorrect assignment depending upon the provider taxonomy of the submitting clinician. In the Medicare population, principal care management services (99424 - 99427) are more likely to be specialist services than primary care, as supported by 2020 Medicare claims data for G2064, the predecessor code for 99424. Advance care planning services (99497, 99498) are often reported by hospitalists and NPPs in specialty practices. Cognitive assessment and care planning (99483) is more commonly reported by neurology than internal medicine or family medicine. Health risk appraisal services (96160, 96161) would rarely be relevant alone, are very nonspecific and frequently used by specialists.

As noted above, CMS proposed to maintain its current policy not to recognize subspecialties. Under this policy, advanced practice nurses and physician assistants working with physicians are always classified in a different specialty than the physician with whom they practice. The 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. To avoid this situation, we recommend that CMS revise the taxonomy codes to provide more granularity and differentiate between NPPs who are working in primary care and those working in specialty practices.

Correct assignment is very important. For example, drugs used to treat oncology patients are extremely high cost and have experienced price increases much greater than overall inflation. Incorrect attribution of oncology patients to an ACO due to services furnished by oncology APRNs can distort the validity of the spending benchmark. **The AGS believes that the codes identified above contribute to inaccurate attribution and should not be used. We ask CMS to proposed changes to the list of primary care services to exclude these codes and to create a more granular taxonomy for APRNs and PAs.**

## **XVII. 2023 Quality Payment Program (QPP) Proposals**

### **A. Geriatrics Specialty Measure Set**

#### Addition of Adult Immunization Status and removal of Preventive Care and Screening for Influenza Immunization (Measure #110) and Pneumococcal Vaccination Status (Measure #111)

The AGS believes that staying current with the Centers for Disease Control and Prevention (CDC) recommendations is particularly important for adults 65 years and old given their increased risk of severe complications from vaccine preventable illnesses.<sup>16</sup> As an example, older adults are at greater risk of serious complications from the flu compared to younger, healthy adults since human immune defenses are weakened with age. Between 70 and 85 percent of flu-related deaths occurred in adults 65 years and older and between 50 and 70 percent of hospitalizations related to the flu occurred in this population.<sup>17</sup>

**The AGS supports removal of the Preventive Care and Screening for Influenza Immunization (Measure #110) and Pneumococcal Vaccination Status (Measure #111).** We support the concept of including a more comprehensive immunization status measure, but we have some concerns about the

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<sup>16</sup> American Geriatrics Society. The AGS Statement on Immunization in Older Adults. Published March 2022. Accessed August 23, 2022. <https://www.americangeriatrics.org/sites/default/files/inline-files/AGS%20Vaccine%20Policy%20Statement%20FINAL%20rev.pdf>.

<sup>17</sup> Centers for Disease Control and Prevention. Flu & People 65 Years and Older. Published June 23, 2022. Accessed August 23, 2022. <https://www.cdc.gov/flu/highrisk/65over.htm>.

applicability and practicality of the proposed Adult Immunization Status measure, which includes immunizations for influenza, tetanus and diphtheria (Td) and Tdap, zoster, and pneumococcal. The Adult Immunization Status measure is a Healthcare Effectiveness Data and Information Set (HEDIS) measure developed by the National Committee for Quality Assurance (NCQA) for reporting by health plans that have access to more comprehensive claims information to inform an enrollee's immunization status. On the other hand, individual clinicians and groups often lack records confirming immunization status. A number of the vaccines covered by this measure currently are reimbursed only when administered at the pharmacy under Medicare Part D (e.g., Tdap and zoster) and beneficiaries may choose to receive most of the covered vaccines at the pharmacy. Moreover, provider access to state immunization registry data is uneven at best with some states charging providers for access to such data for their patients.

**If CMS finalizes the addition of this measure for MIPS, we urge CMS to clarify that eligible clinicians and groups may satisfy this measure by documenting patient-reported immunization status, in lieu of data from the patient's electronic medical record or a state registry.**

#### Kidney Health Evaluation

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,<sup>18</sup> 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.<sup>19,20,21</sup> **The 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.**

#### Depression Remission at Twelve Months (Measure #370)

The AGS is concerned about the Depression Remission at Twelve Months (Measure #370) that was previously finalized 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 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 or higher.<sup>22,23</sup> Thus, **this may not be an appropriate measure for the Medicare population.** Moreover, geriatricians, who see the oldest and sickest patients, may not perform as well on this measure compared to other provider types simply as a result of the patient population they serve.

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<sup>18</sup> National Kidney Foundation. Aging and Kidney Disease. Accessed August 23, 2022. [https://www.kidney.org/news/monthly/wkd\\_aging](https://www.kidney.org/news/monthly/wkd_aging).

<sup>19</sup> O'Hare AM, Rodriguez RA, Rule AD. *JAMA Intern Med.* 2021;181(10):1366-1368. doi:10.1001/jamainternmed.2021.4823

<sup>20</sup> 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

<sup>21</sup> 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

<sup>22</sup> 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

<sup>23</sup> 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

## B. Proposed MVPs

The AGS appreciates that CMS is proposing additional MVPs that are intended for primary care physicians, such as chronic disease management and promoting wellness. **While these may seem appropriate for geriatrics health professionals in theory, given the heterogeneity of the patient population they care for,<sup>24</sup> it may be difficult for geriatricians to be successful under the MVP framework.** As an example, the breast and CRC screening measure from the promoting wellness MVP would not be appropriate for patients with limited life expectancy. Geriatrics health professionals are focused on the whole person, taking into consideration the patient's functionality, chronic medical conditions, what matters to them, and more and would address prevention accordingly. Measures are difficult to specify at this level and it is not as simple as removing patients from a denominator if in hospice. Geriatricians are likely to have a proportion of such patients that is different than other primary care clinicians who care for other patients that would meet the denominator criteria. In the examples above the CRC group would be skewed to over 65 and have a higher number of patients for whom screening would not be medically appropriate.

## C. Subgroup Eligibility Policies for MIPS Value Pathways (MVPs)

Subgroup reporting will be voluntary for the CY 2023, 2024, and 2025 performance periods (2025, 2026, and 2027 MIPS payment years). Multispecialty groups that choose to report through an MVP will be required to participate as subgroups beginning with the CY 2026 performance period (2028 MIPS payment year). To allow flexibility for groups to explore the different ways they could utilize subgroups, CMS is not proposing any restrictions related to the composition of a subgroup. Instead, CMS is proposing that a group must submit a description of each subgroup at the time of registration to help CMS understand the underlying rationale for how groups placed clinicians in a subgroup and utilize these characteristics to shape subgroup criteria in the future. A tax identification number (TIN) could choose to form more than one subgroup for reporting MVPs. However, due to operational complexity, CMS is proposing that an individual eligible clinician—as represented by a TIN and national provider identifier (NPI) combination—may register for no more than one subgroup within a group's TIN.

**While we appreciate CMS's goal of leveraging MVPs to develop comparable performance data across like entities that helps patients make informed healthcare decisions, we remain concerned that subgroup reporting provides limited benefit to actually improving healthcare quality and creates significant complexity, counter to CMS's goal of reducing reporting burden.** Medicare beneficiaries—particularly those with multiple chronic conditions—benefit from coordinated, team-based, and population healthcare services. Subdividing multispecialty groups that are designed to advance this team-based approach for the purposes of quality measure reporting undermines these efforts. Additionally, while the proposed number of measures within a single MVP may be fewer than traditional MIPS, multispecialty groups may need to report a greater number of measures in total to address the MVP for each of its subgroups.

Today, multispecialty groups are reporting population-based measures that hold every group member accountable for patient outcomes and costs regardless of specialty, which we believe more appropriately aligns to the goals of team-based care. **As CMS moves toward the MVP model, the AGS urges the agency to think carefully through MVP selection, registration, reporting, attribution, and scoring rules—particularly with respect to subgroups—in order to avoid overcomplicating a pathway**

**that is intended to streamline MIPS.** For example, would groups (i.e., TINs) have to register their identified subgroups as MVP Participants or could a group of clinicians independently register themselves as MVP Participants? Conversely, could an eligible clinician be placed in a subgroup or multiple subgroups without his or her knowledge? In our experience, multispecialty groups collect information for MIPS reporting on behalf of their eligible clinicians. Subgroup reporting will complicate this process, particularly if groups do not have control over the subgroups and where the same clinician may participate in multiple subgroups.

**D. Public Health and Clinical Data Exchange Objective**

Beginning in 2022, CMS requires MIPS eligible clinicians to report two measures under this objective: Immunization Registry Reporting and Electronic Case Reporting. CMS believes that these two measures will put public health agencies on a better footing for future health threats and long-term COVID-19 recovery by strengthening two important public health functions: (1) case surveillance; and (2) vaccine uptake.

The AGS agrees with CMS about the value of these measures. **We urge CMS to require submission of these measures by other entities such as Advanced APM entities and pharmacies that provide Part D immunizations and the reporting to be bi-directional – that is the medical organization should also receive as well as submit information from the registry.**

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, [agoldstein@americangeriatrics.org](mailto:agoldstein@americangeriatrics.org).

Sincerely,



Michael Harper, MD  
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Nancy E. Lundebjerg, MPA  
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