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

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February 28, 2023

Gift Tee
Director, Division of Practitioner Services
Hospital and Ambulatory Policy Group
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Medicare CY 2024 Payment Policies Under the Physician Fee Schedule

Dear Mr. Tee:

The American Geriatrics Society ("AGS") greatly appreciates the opportunity to provide input on issues that we hope the Centers for Medicare & Medicaid Services (CMS) will address in the Physician Fee Schedule (PFS) proposed rule for 2024. 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 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 recommend that CMS include the following items in the 2024 PFS proposed rule:

- Reaffirm the need for the visit complexity add-on code (G2211) and clarify that the code is intended for services that are part of comprehensive longitudinal care of patients with complex care needs;
    - Revise the descriptor for G2211 to identify the level of visit likely to involve additional complexity (i.e., visits with moderate or high medical decision-making)
    - Clarify the expectation that the add-on code is appropriate for longitudinal care furnished to a patient that is seen on an ongoing basis;
- Recognize as active and assign relative value units (RVUs) for caregiver training codes (96202, 96203, 9X015, 9X016, 9X017);
- Revise the "incident to" and other policies to allow billing for new patients and to allow team care for home visits;
- Continue to allow reporting of shared visits based on medical decision-making (MDM) beyond December 31, 2023;
- Align Medicare payment policy and valuation for prolonged evaluation and management (E/M) services with CPT coding and guidance; and
- Create a more granular taxonomy for non-physician practitioners (NPPs) that identifies the NPP's type of practice: primary care, specialty care, and behavioral care.

We describe these recommendations in greater detail below.

A. Visit Complexity

CMS adopted the add-on code for visit complexity (G2211 *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*) to be implemented in 2021. Congress delayed implementation until at least January 1, 2024. Although CMS' statements in rulemaking since 2021 suggest the code is still necessary, the agency has not otherwise addressed how or when the code will be implemented.

AGS believes that the revised E/M codes do not adequately capture the complexity that is part of providing comprehensive longitudinal care for patients with complex care needs and that an add-on code to capture this complexity is necessary and should be implemented. Visits that are part of this comprehensive, ongoing care often involve a care team, which can require substantial collaboration and coordination as the team prepares for, executes, finishes, and follows up on the visit. These types of visits may be part of caring for a multimorbid complex patient or a patient with a single serious condition. 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.

Primary care teams have greater care coordination requirements than other practitioners and therefore perform work that is not recognized in existing code descriptors and valuations. This work is distinct from the usual care coordination services that may be furnished between visits. Instead, this complexity is an inherent part of the visit and results in greater inter-visit work and practice expenses. In most cases, however, this additional work would not typically meet all the requirements to report chronic care management or principal care management codes, nor would it necessarily meet the time requirements of prolonged services.

The obligation of longitudinal care creates a greater level of work at the visit and during the inter-visit interval. This kind of visit complexity is distinct from the level of medical decision-making (MDM) required during the visit. MDM is based on discrete factors such as the number and complexity of the problems being addressed in the visit; the amount and complexity of data to be reviewed; and the risk of complications and/or morbidity or mortality of patient management decisions. Rather than involving a specific extra component, we believe that visit complexity represents the additional work and resources needed to care for seriously ill patients on an ongoing basis. This added work typically occurs with visits requiring moderate or high-level MDM and is unlikely to occur during visits coded as 99202, 99203, 99211, 99212 or 99213.

AGS believes it is appropriate to identify and report this complexity through an add-on code such as G2211 but the descriptor for G2211 should be refined to better capture this concept. The initial utilization assumptions in budget neutrality calculations assumed very broad use of this code. These assumptions and the budget neutrality requirement resulted in opposition to the concept and federal legislation. As a practical matter, to avoid a repeat of the response, there needs to be a more targeted application. This would also seem to be more consistent with the goals and the descriptor. We believe the primary care clause "associated with medical care services that serve as the continuing focal point for all needed health care services" is clear. We have concerns that the terms "serious", "complex", and "ongoing" may need clarification. When CMS created the chronic care management services codes and principal care management codes, they provided additional guidance in the descriptors. The same type

text may be appropriate (recognizing the care management codes have specifications related to number of conditions and comprehensive nature of the care plan). We suggest text that is not identical to care management codes to indicate that these patients may not all be eligible for chronic or principal care management.

We recommend that CMS revise the code descriptor to specify that use is limited to higher level visits by adding the text underlined in red below. We also recommend that CMS clarify that the code can be used when caring for patients with a single condition that is serious but not a "single" condition. This could be done by eliminating the comma between "single" and "serious" in the code descriptor. We also suggest CMS consider the additional components (or a similar refinement) listed as bullets and underlined in red:

G2211 Visit complexity inherent to evaluation and management associated with medical care services with the following elements:

- Services that serve as the continuing focal point for all needed health care services, or
- Care for a single serious condition or one or more complex condition(s), which are expected to require ongoing management between visits, at least two visits a year and which require treatment decisions of at least moderate risk over the course of care to avoid functional loss, serious morbidity or mortality.

(Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established, 99204, 99205, 99214 or 99215)

To ensure that the additional payment is targeted to services that involve additional complexity, CMS should develop additional guidance on how G2211 should be used. AGS asks that CMS explicitly state that the code is intended to describe visit complexity in the context of primary comprehensive longitudinal care and provide additional guidance to ensure practitioners can accurately report that such care is occurring.

CMS may wish to consider whether the patient relationship modifiers X1 or X2 (continuous/broad and continuous/focused relationships respectively) should be used to identify which practitioners should be reporting G2211.

We also recommend that CMS clarify that G2211 can be reported with the home or residence visit codes at the higher levels (99344, 99345, 99349 and 99350), as we believe the same resource considerations apply to this code family as well.

We believe that adoption of the above refinements would both ensure that the additional money is spent on services that actually reflect higher complexity and reduce the impact of utilization of the add-on code on the conversion factor.

B. Caregiver Training Codes

CPT has established new codes for CPT 2023 and CPT 2024 for caregiver training including multiple-family group behavior management training. Table 1 shows the codes and descriptors and the effective date for these codes.

Table 1
Caregiver Training Codes

Code	Descriptor	Effective Date
96202	Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; initial 60 minutes	January 1, 2023
96203	Multiple-family group behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers; each additional 15 minutes (List separately in addition to code for primary service)	
9X015	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes	January 1, 2024
9X016	each additional 15 minutes (List separately in addition to code for primary service)	
9X017	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers	

For 2023, CMS did not recognize 96202 or 96203 because the training described by the codes is furnished to caregivers without the patient present and therefore, CMS is concerned that the Medicare statute may preclude coverage of the service.

AGS does not believe that the statute limits coverage of these services. Caregiver training services clearly benefit the patient and meet 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"[1] of an individual Medicare beneficiary. These services enable caregivers to better address the patient's needs and provide the caregiver with technical skills to reduce the impact of the patient's diagnosis ***on the patient's*** daily life. Family caregivers continue to provide the majority of long-term care for older Americans and others with disability – often without sufficient training or support. The training can provide assistance in performing activities of daily living, medical/nursing tasks, coordinating care, and prepare caregivers to better implement necessary elements of care plans to benefit the patient. Caregivers are an essential support for the increasing number of older people with chronic illnesses and complex conditions. Training can help caregivers become more effective and deal with the stressors of caregiving resulting in better health of the older adult.[2] The training described by these codes is an important element of patient-centered care.

Comprehensive dementia care programs, for example, teach caregivers about dementia, problem-solving strategies, skills to combat patient and caregiver stress, creating a safe home environment, and how to effectively communicate with someone who is confused. Despite evidence

[1] Social Security Act 1862(a)(1)(A).

[2] Mason NR, Sox HC, Whitlock EP. A Patient-Centered Approach to Comparative Effectiveness Research Focused on Older Adults: Lessons from the Patient-Centered Outcomes Research Institute. *J Am Geriatr Soc.* 2019;67(1):21-28. doi:10.1111/jgs.15655

highlighting the effectiveness of such programs, they are not widely available.[3,4] We understand CMMI may be asked to consider a demo to pilot a dementia care model, however, we believe that Medicare coverage of the caregiver training codes is an opportunity to make a difference in the care of dementia patients in 2024. The skills these programs teach and the positive patient benefits are represented by the five CPT codes for which we request coverage.

In the 2023 final rule, CMS identified instances where Medicare pays for care furnished to beneficiaries by direct involvement of caregivers or in instances where the patient is not physically present at the interaction. CMS stated that it made payment in those circumstances because the lack of coding and payment gave rise to "inappropriate payment disparities that do not reflect the relative resources involved in furnishing treatment, given the changes in medical practice that have led to more care coordination/team-based care, and the idea that the resources involved in those aspects of care are not adequately reflected in current coding/payment."[5] These circumstances also apply to the two new families of caregiver training codes. Team-based care is the standard of care, particularly for complex older patients with multi-morbid conditions. Caregivers are vital members of the care team and existing codes do not reflect the resources required to effectively incorporate caregivers into the care plan.

Lack of coding and payment exist for these services which promote the well-being of vulnerable populations e.g., the disabled, those with developmental disorders or dementia. The care management services that CMS recognizes are not available to the professionals who provide these services: psychologists, clinical social workers, physical, occupational and speech therapists. Comprehensive teams do not exist for all these patients and "incident to" is not an alternative, nor would physicians and NPPs know how to report the service.

CMS noted in reference to behavioral health services:[6]

The Medicare Coverage Determinations (NCD) Manual, Pub. 100–03, section 70.1, titled ''Consultations with a Beneficiary's Family and Associates'' states that ''family counseling services are covered only where the primary purpose of such counseling is the treatment of the patient's condition.''.

That same NCD states:

> For example, two situations where family counseling services would be appropriate are as follows: (1) where there is a need to observe the patient's interaction with family members; and/or (2) where there is a need to assess the capability of and assist the family members in aiding in the management of the patient. Counseling principally concerned with the effects of the patient's condition on the individual being interviewed would not be reimbursable as part of the physician's personal services to the patient. While to a limited degree, the counseling described in the second situation may be used to modify the behavior of the family members, such services nevertheless are covered because they relate primarily to the management of the patient's problems and not to the treatment of the family member's problems.

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[3] National Academies of Sciences, Engineering, and Medicine. 2021. *Meeting the Challenge of Caring for Persons Living with Dementia and Their Care Partners and Caregivers: A Way Forward.* Washington, DC: The National Academies Press. https://doi.org/10.17226/26026.

[4] Judith Graham, Dementia Care Programs Help, If Caregivers Can Find Them, (KFF, February 27, 2023) Dementia Care Programs Help, If Caregivers Can Find Them | Kaiser Health News (khn.org) (February 27, 2023)

[5] 87 Fed. Reg. 69522.

[6] 87 Fed. Reg. 69555.

Consider these two examples:

For 96202, 96203: A patient with moderate dementia is cared for at home by a spouse with assistance from a family member on occasion. The patient has begun to exhibit agitated behavior making it difficult to provide for the basic needs and safety of the patient. The family wonders about medications or facility placement. The PCP refers the family to a social worker with expertise in dementia care who explores the precipitants of the agitation and trains the caregivers in techniques that reduce the events, such as not trying to use logic with a patient who cannot comprehend and just letting non-essential care be delayed. As a result, potentially inappropriate medications[7] are not needed and the patient is maintained in the least restrictive community setting.

For 9X015-9X017: A patient post stroke has deficits of hemiplegia and is at risk for aspiration. The family caregiver wishes to keep the patient at home, but there have been near misses with falls and the caregiver admits the dietary and swallowing techniques are confusing. The patient has had some choking episodes. An occupational therapist and speech therapist provide training in methods to support the patient's ADL functions. As a result, the risk of trauma and aspiration are reduced.

Medicare should recognize and pay separately for caregiver training services to facilitate access to training and improve patient care which has a direct impact on the patient, whether or not the patient is present for the service.

If CMS is only willing to pay for these services only when the patient gives permission or is notified that a caregiver training service is to be furnished, then we can 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 or other conditions that would impair consent capacity.

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 emergency room visits. Not recognizing the codes exacerbates health inequities by creating barriers to improved care for patients with dementia who are at greater social and economic disadvantage compared to the broader patient population. **We strongly recommend that CMS recognize these codes for payment by Medicare and assign RVUs to value these services.**

C. "Incident To" Visits for New Patients

Currently, CMS limits billing of services, including E/M visits, "incident to" a physician or practitioner service to established patients and problems, which means that only services furnished after the physician has established a plan of care and which are furnished to carry out that plan of care can be furnished under the policy. That longitudinal approach, however, no longer reflects the standard of care, which for geriatrics and many other specialties is team-based care. That is, new patients are seen by physicians or NPPs under the direct supervision of physicians, the clinicians jointly develop the care plan for both new and established patients, and work together to furnish the services needed to carry out that plan.

[7] (2019), American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. J Am Geriatr Soc, 67: 674-694. https://doi.org/10.1111/jgs.15767

CMS should revise its "incident to" policy to include new patient visits performed by NPPs, when that practitioner is acting within the scope of their license and is under direct supervision of a physician. Such clarification would conform CMS policy with the current standard of care and will facilitate team-based care. It would also align the "incident to" policy that applies to services in the office setting with the Shared/Split visit policy. The Shared/Split visit policy applies to facility services and allows for shared/split visits to be furnished to new patients. Allowing new patients to be seen by a NPP furnishing the service on an "incident to" basis will improve access to outpatient care by increasing the number of providers who can perform new patient visits. Alternatively, CMS may elect to **clarify** that an "established plan of care" includes one that is jointly established with the physician at the time of the new patient visit. We urge CMS to make this clarification as part of rulemaking for 2024.

D. Identification of Substantive Portion of 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, 2024, 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. A shared visit can only be billed by the physician if the visit is billed based on total time and if the physician accounts for more than 50 percent of the total time of the visit. In almost all cases, the result is that the reporting clinician will be the NPP.

AGS has strongly disagreed with this approach in our comments on the 2022 and 2023 PFS rules. We do not believe that the substantive portion should be determined based solely on time, particularly because CMS policy specifically states that the substantive portion does not require patient contact.[8] MDM, which is the most important part of any E/M visit, should **continue to 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. It has long been the basis for determining who may report the service and a change in policy is not needed. Billing shared visits based on time alone will disincentivize team-based care and result in an inefficient allocation of physician and NPP resources.

AGS recommends that CMS revise its policy to continue to allow a split visit to be billed based on EITHER time OR medical decision making. We agree that when time is used to select the level, time should determine the substantive portion. Therefore, **u**nless documentation in the medical record clearly indicates that the physician spent the majority of time or was responsible for the medical decision making, the visit should be billed by the non-physician.

We also recommend that CMS extend its shared visit policy to certain home and nursing facility 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. The "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) services when the patient is in a nursing facility (and not a **skilled** nursing facility). While we understand that regulations require certain visits be performed by the physician, other nursing facility visits may be furnished by an advanced

[8] "For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact." (Medicare Claims Processing Manual, Chapter 12, Section 30.6.18 B(3))

practice nurse. During those visits, the nurse practitioner determines the care or performs the MDM in conjunction with the physician. The same split (or shared) visit policy should apply to those services as to other facility E/M services.

E. **Prolonged Services**

We strongly disagree with CMS' approach to prolonged E/M services. Rather than recognizing the CPT codes describing prolonged services involving direct patient contact (99417 and 99418), CMS adopted new healthcare common procedure coding system (HCPCS) G-codes to describe prolonged services for hospital inpatient and observation care (G0316), nursing facility care (G0317), home or residential care (G0318), and office or other outpatient services (G2212). CMS took 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. Under the CMS policy, the prolonged service period starts 15 minutes after the threshold time and cannot be billed until full 15 minutes of time beyond the threshold has been provided. The threshold time is based on the time included in the Physician Time File maintained by CMS. The period over which the time is measured is based on the specifications of the RUC survey and varies for each code family (i.e., the date of the visit for inpatient and observation care vs the period that begins three days before and ends 7 days after the date of the visit for home and residential care).

AGS strongly disagrees with this approach for several reasons. First it is extremely complicated to administer. The threshold time and applicable period varies based on the code family. In order to determine whether a service qualifies to be reported as prolonged, physicians and billing staff must consult obscure files, appropriately round values, and accurately track time over time periods that vary by site of service. This complexity will undoubtedly lead to billing errors. Second, the CMS approach consistently undervalues care to the most complex patients, because the first 15 minutes of extended care beyond the typical time for the highest-level code routinely goes unpaid for each and every prolonged service.

Third, the CMS approach incorporates into the code selection process RUC survey information that is gathered for use in code valuation. This is methodologically inappropriate and is not an approach that CMS has taken with other services. Using the RUC survey parameters as the framework for determining when a service qualifies as prolonged distorts the relativity between E/M services and other PFS services where CMS has not taken this approach. We appreciate that following our meeting in January, CMS asked questions to better understand the RUC surveys and recommendations. Those questions and our responses are also attached to this letter.

To resolve these issues, AGS strongly recommends that CMS take the following steps:

- **Discontinue G0316, G0317, G0318, and G2212;**
- **Recognize the CPT prolonged services codes (99417 and 99418) and the RUC recommended values for those codes; and**
- **Adopt the CPT guidance for prolonged services (including basing prolonged service only total time on the date of the encounter).**

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

In rulemaking for 2023, CMS maintained its current policy that advanced practice nurses and physician assistants working with physicians are always classified in a different specialty than the physician. However, CMS indicated that it is considering whether this provider taxonomy aligns with clinical practice.

We do not believe it does and urge CMS to better refine the provider taxonomy for NPPs. Under the current taxonomy, NPPs who work with specialty physicians are not classified as specialty care providers and instead appear to be primary care practitioners. As a result, Medicare alternative payment models and programs which rely on primary care designations for patient assignment may inappropriately assign beneficiaries based on the care furnished by the specialty NPP. This can distort the cost metrics used to assess organization performance by assigning a beneficiary to an organization that is not managing their primary care. For example, incorrect attribution of oncology patients to an Accountable Care Organization (ACO) due to services furnished by oncology NPPs can distort the validity of the spending benchmark used to measure the performance of the ACO.

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.**

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Thank you for the opportunity to submit these recommendations and for meeting with us to discuss them. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,

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Chief Executive Officer