

Protect and Improve Patient Access to Primary Care

The Society of General Internal Medicine's (SGIM) members are often the frontline providers delivering care to complex and medically vulnerable patients. They understand that high quality, comprehensive primary care provided in a patient-centered medical practice not only improves patient outcomes but also reduces healthcare costs and enhances provider work satisfaction. A recently published study found that for every 10 additional primary care physicians per 100,000 patients in a population, there was an associated 51.5 day increase in life expectancy.¹ However, the current physician reimbursement system does not adequately recognize the value that coordinated primary care delivery produces for patients and the healthcare system, putting patient access to effective primary care at risk.

The Centers for Medicare & Medicaid Services (CMS) is statutorily required to maintain a Medicare Physician Fee Schedule that assigns values to services relative to the others included in the fee schedule. CMS updates these values annually. In the CY 2019 Physician Fee Schedule proposed rule, CMS chose to address the burdensome charting and excessively repetitive notes required by the outpatient E/M documentation guidelines by significantly revising the documentation requirements and payment for these services. However, the very definitions and valuations of E/M services themselves are a significant cause of burden for the providers who primarily bill them. Without addressing this, the health of Medicare beneficiaries and the success of Medicare payment innovations is threatened.

E/M service codes were never defined to reflect complex medical decision making like that required by the practice of general internal medicine. These code definitions have remained essentially unchanged even as the content and complexity of medical care has grown over the last two decades. Consequently, Medicare payments to primary care and other cognitively intense specialties have declined in comparison to those made to procedurally based specialties. This payment disparity has led to workforce shortages and inconsistencies across a range of specialties, including primary care, infectious disease, endocrinology, and neurology.

Without a robust cognitive workforce, patient access to comprehensive chronic care like that provided by our members is at risk. CMS must recognize the complexity of services delivered by primary care physicians. Many experts believe that the future of primary care in the United States

¹ Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med.* 2019;179(4):506–514. doi:10.1001/jamainternmed.2018.7624

depends on payment reform that recognizes the value of primary care and other cognitive services. **CMS must correct the deficiencies in the E/M service codes to address workforce shortages, reduce physician burden and implement successful value-based payment models.**

We applaud CMS for its willingness to revise E/M documentation and payment. However, the impact of the E/M payment changes on different specialties and overall fee schedule spending included in the CY 2019 Physician Fee Schedule final rule scheduled to be implemented on January 1, 2021 appear to be inaccurate. An independent data analyst was unable to replicate CMS' calculations and believes that the agency did not apply the budget neutrality adjustment.

CMS must address this inaccuracy in the CY 2020 Physician Fee Schedule proposed rule in one of two ways: provide accurate impact assessments and allow stakeholders to comment or rescind the policy. SGIM believes that the agency should do the latter and instead solicit input possible from the professional community, review the existing literature, and perform additional analysis on the data already available on E/M services in the Medicare database and in EHRs to develop a new evidence based proposal to redefine and value E/M services. Evidence based changes made to the E/M payment structure have the potential to improve patient access to care and address existing workforce shortages and discrepancies.

In 2016, spending on E/M services totaled \$47.455 billion, an increase of \$1.473 billion from 2015. CPT code 99214, the mid-high level established patient office visit, experienced an almost 22 percent utilization increase from 2010 to 2015. Given the significant amount of Medicare spending represented by these services, CMS must get its E/M policy correct. To do so, SGIM recommends they develop an evidence-based payment proposal. **Congress must urge CMS to establish an open and publicly accountable process to rework the outpatient E/M codes and take as much time as necessary to ensure that any changes made to the E/M payment structure will not disrupt Medicare beneficiaries' access to comprehensive primary care services.**

For further information, please contact Erika Miller at emiller@dc-crd.com or 202-484-1100.