September 1, 2022

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov

RE: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1770-P)

Dear Administrator Brooks-LaSure:

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule for calendar year (CY) 2023 Medicare Physician Fee Schedule (MPFS). SGIM is a member-based medical association of more than 3,300 of the world’s leading academic general internists, who are dedicated to improving the access to care for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to ensuring patients have equitable and affordable access to the highest quality of care possible.

As such, we look forward to commenting on the following sections of the proposed rule:

• Conversion Factor Update
• Evaluation and Management (E/M) Visits
• Payment for Medicare Telehealth Services
• Strategies for Improving Global Surgical Package Valuation
• Request for Information: Medicare Potentially Underutilized Services
• New Coding and Payment for General Behavioral Health Integration
• Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs
• Medicare Shared Savings Program
• Changes to the Quality Payment Program

Conversion Factor Update

The conversion factor for 2023 is set to decrease by approximately 4.5 percent from $34.6026 to $33.0775. This decrease is due to the expiration of the 3 percent increase to payments which was authorized by the Protecting Medicare & American Farmers from Sequester Cuts Act (P.L. 117-71), but is due to expire at the end of 2022, as well as the mandated 0 percent conversion factor increase and the required budget neutrality adjustments. These cuts, as well as the 4 percent PAYGO cut to the Medicare program, will be devastating to physicians and their
patients, particularly as they continue to combat the effects of COVID-19. Furthermore, it is important to note that Medicare physician payments have not kept pace with inflation, and have declined by 20 percent from 2001 to 2021 in inflation-adjusted dollars.\(^1\) **SGIM is aware that CMS does not have the statutory authority to mitigate these cuts; however, we hope the agency will continue to work with Congress to address this issue before the end of the year.**

**Evaluation and Management (E/M) Services**

**Inpatient and Observation Codes**

SGIM appreciates the work CMS has done to update the E/M code families, beginning with the outpatient E/M services, and now proposing to adopt nearly all the revisions for CPT® codes used to report other E/M visits, including inpatient and observation services. The changes being implemented include revisions to the descriptors for these services and the documentation guidelines, which will now mirror those previously made to the outpatient E/M services, providing consistency across the E/M code family and reducing unnecessary documentation burden. **Additionally, SGIM members support the change to the inpatient and observation services that will no longer require physicians and their coders to distinguish between these two statuses to bill correctly. We urge CMS to finalize its proposal to create new HCPCS codes for prolonged services associated with certain types of E/M services—GXXX1, GXXX2 and GXXX3—when billing by time.**

Despite the agency’s efforts, SGIM is concerned that the values of the inpatient and other E/M services continue to be inaccurate despite the recent revaluation. We recognize that CMS has proposed to adopt the Relative Value Scale Update Committee (RUC) recommended values; however, CMS is proposing to reduce the value of some of the inpatient services despite the complexity of this work, and when finalized, they will be valued less than the comparable outpatient service. For example, CPT code 99205, the highest level new outpatient service code, and CPT code 99223, the highest level initial hospital care code, are valued at 5.39 RVUs and 5.19 RVUs respectively in the facility setting. SGIM is concerned that these reductions to the initial inpatient services may distort the relativity of the MPFS. Inpatient care is often more complex and resource intensive as these services require hospital admission; however, once finalized, the lower value of the inpatient services signal they are less complex and less resource intensive than the outpatient services. **SGIM urges CMS to ensure that the changes in the fee schedule maintain relativity and asks the agency to consider looking beyond the RUC process to properly value E/M services.**

Furthermore, in the proposed rule, CMS states, “To the extent we are proposing to adopt the RUC-recommended values for Other E/M visits beginning for CY 2023, we do not agree with the RUC that the current visit payment structure among and between care settings fully accounts for

the complexity of certain kinds of visits, especially for those in the office setting, nor do they fully reflect appropriate relative values, since separate payment is not yet made for G2211.”

SGIM agrees that a complexity add-on code is a means to properly valuing these services; however, we think the expert panel proposed by the Cognitive Care Alliance, which was formed and is currently led by SGIM, would support a data driven, evidence based approach to appropriately value E/M work.

As originally conceived, Medicare payments were to be priced relative to one another based on work intensity. The model of Willian Hsiao proposed four aspects that would contribute to work intensity including time for service delivery, mental effort, technical skill, and stress. As CMS points out, the practice of medicine is ever changing with new interventions, improved technologies, and more efficient workflows. SGIM is fully supportive of CMS efforts to continually address distortions in the pricing of patient care services; however, the process by which services are themselves valued requires more attention.

For these reasons, SGIM believes an expert panel can serve an important role in ensuring E/M and other cognitive services are appropriately valued using the best available data to reflect the complexity of care delivered. An expert panel will ensure that these services are evaluated at more regular intervals limiting significant redistributive effects associated with major valuation and policy changes as we have seen in recent years. We believe that an independent assessment of available data and the resulting data driven policy recommendations will stabilize what has evolved to become an irregular process and help maintain an appropriate balance in the MPFS, which may also have the added benefit of improving access to a well-trained primary care workforce. A full description of the panel and its proposed scope is included in Appendix A of these comments.

Split/Shared Services
In 2022, CMS finalized, but then delayed a proposal which stated that the practitioner who billed the split/shared service should be based on substantive time, defined as more than 50 percent of total time, spent with the patient. CMS is proposing to delay the much-debated split/shared services policy for another year, until 2024. SGIM supports this additional delay and encourages the agency to collaborate with stakeholders to ensure this policy does not increase burden on providers and that it aligns with the agency’s efforts to prioritize team-based care. Specifically, we recommend that the agency allow billing by MDM or time for these services. This change will reduce burden on providers and be more consistent with the rest of the E/M families. Should CMS choose to allow MDM as a determinate of billing, there should be clear requirements for demonstrating that the billing provider, either the physician or non-physician practitioner, developed their own critical thinking and planning. SGIM welcomes the opportunity to work with CMS to improve this policy.

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Payment for Medicare Telehealth Services

Changes to the Medicare Telehealth List
SGIM commends CMS’ proposal to allow all services that were added to the telehealth list on a temporary basis during the public health emergency (PHE), including those that have not been converted to Category 1, 2 or 3, to remain available through the 151-day period after the end of the PHE, during which certain PHE-related flexibilities will be maintained. Our members have continued to adjust their practices to utilize telehealth services and believe Medicare should continue to support virtual care post-pandemic as its statutory authority allows.

Furthermore, SGIM supports CMS’ proposal to add additional services to the Medicare telehealth services list with a Category 3 designation. In addition, we recommend CMS finalize the proposal to add the new HCPCS codes for prolonged services associated with certain types of E/M services—HCPCS codes GXXX1, GXXX2 and GXXX3—to the telehealth list on a Category 1 basis to replace the existing prolonged service codes. SGIM urges CMS to finalize these policies as proposed.

SGIM recognizes that CMS denied a request to add the telephone E/M services to the telehealth list on a Category 3 basis because the agency defines telehealth services as having a simultaneous audio/video connection and does not view these services as equivalent to those delivered face-to-face. The ability to deliver telephone E/M services has been extremely important for Medicare beneficiaries who lack access to high-speed internet or the technology necessary for video visits. Through these visits, SGIM members have successfully managed various chronic diseases, including but not limited to diabetes and hypertension. Eliminating this flexibility will limit access to some of the most vulnerable Medicare beneficiaries. In fact, SGIM members have experienced first-hand that when employed wisely, as decided by a patient and physician together, telephone E/M visits can help increase access, improve health outcomes, reduce disparities, and improve patient satisfaction. There are data showing that telephonic care leads to drastically lower “no-show” rates compared to other modalities; uptake of telephone E/M is higher among older, rural and black Americans as well as other vulnerable populations; and patients’ satisfaction is equivalent to audio-visual care.4,5 Therefore, SGIM will continue to work with Congress to address this issue so that CMS has the authority to cover telephone E/M services beyond mental health services after the PHE concludes.

Reimbursing Telehealth Services at the Facility Rate
CMS restated its policy to reimburse for telehealth services at the facility payment rate after the PHE expires as the agency believes this reimbursement rate best reflects the direct and indirect practice expenses of telehealth services. SGIM strongly disagrees with this and urges CMS to

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4 https://bipartisanpolicy.org/event/not-your-mothers-health-care/
5 Association of American Medical Colleges Congressional Briefing on the Future of Telehealth, https://www.youtube.com/watch?v=KhFmj8CLUXQ
reimburse telehealth services at the physician office rate. We recognize that all virtual visits do not incur identical practice expense costs as in-person visits do. However, we believe the costs are equivalent. To deliver virtual care, practices must make significant investments in the adoption and maintenance of telehealth hardware and software, and these visits require significant staff time to deliver high quality and safe virtual care for patients. Therefore, SGIM recommends that CMS revise this reimbursement policy and maintain payment parity between virtual and office-based care. Respectfully, CMS must ensure appropriate payment policy for all telehealth services to guarantee that physicians may continue to offer them in their practices.

Virtual Direct Supervision
SGIM is pleased with the agency’s decision to continue to allow virtual direct supervision of physician services through December 31 of the year the COVID-19 PHE concludes. SGIM urges CMS to develop a permanent virtual supervision policy and welcomes the opportunity to work with the agency to do so. SGIM strongly believes that this flexibility supports access to care without compromising safety or quality. Without the flexibility for an attending physician to supervise a resident virtually, SGIM members would have had to cancel a significant volume of patient appointments this year at a time when primary care access remains extraordinarily challenging. Virtual supervision has been a reliable option for appropriate attending oversight of clinical care, not materially different from in-person supervision for visits conducted under the primary care exception (PCE) or for telemedicine visits of any type, with an on-site, in-person supervision option available for in-person appointments as needed. There is a growing shortage of general internists, and this flexibility allows them to expand their reach to patients in need of care.

Strategies for Improving Global Surgical Package Valuation
CMS is seeking input on strategies to improve the accuracy of payment for the global surgical packages to ensure that they are valued appropriately. SGIM appreciates the agency’s commitment to determining how to appropriately value global surgical care and is familiar with the RAND report, which found that the reported number of E/M visits matched the expected E/M visits for only 4 percent of reviewed 10-day global packages and 38 percent of reviewed 90-day global packages.6

SGIM members often see patients who are experiencing postoperative complications during the global period, and therefore CMS has paid twice for care that should have been delivered by the surgeon as part of the global surgical period. We agree with CMS that the postoperative health care landscape has changed since the implementation of the MPFS 30 years ago. Advanced technology and better care coordination have led to shortened hospital stays and faster

6 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-
recovery for patients. Further, we agree with CMS that the care management services, which have recently been added to the MPFS, reflect non-face-to-face time spent by physicians and clinical staff, including the transitional care management codes which may cover some of the post operative requirements for safe home recovery.

SGIM will continue to monitor the agency's efforts to evaluate the global surgical packages, which have been underway for several years. We believe CMS must value these services in an evidence-based manner using the best data available and do so as soon as possible. Therefore, SGIM welcomes the opportunity to continue engagement with the agency on this topic.

Medicare Potentially Underutilized Services
The agency has requested comments on the utilization or lack thereof, for high-value services for Medicare beneficiaries. Specifically, the agency is seeking comments on barriers to providing such services, ways to improve access to services, and addressing payment for those services. SGIM members provide or could provide many of the services CMS recognizes as high value and underutilized in the proposed rule, such as annual wellness visits, cardiac rehabilitation services, intensive behavioral therapy for obesity, opioid treatment programs, complex/chronic care management, cognitive assessment and care, and behavioral health integration services. For many of these services, there is significant documentation burden for physicians, inefficiencies in cost sharing, inconsistencies in coverage between Medicare and private payers, and significant resources required to bill for these services. SGIM members have provided the following examples:

- Regarding annual wellness visits, patients incur a co-payment and often they are unsure why, or they are reluctant to pay cost sharing for a service that they did not know was being provided. Additionally, it is hard to ask a patient for a separate visit for this service because patients do not value the annual wellness visit the same as the primary care physician does.
- SGIM members in larger health systems report that their organizations dedicate a considerable number of resources to implement the necessary processes for billing and performing the annual wellness visits. For example, larger organizations train staff and implement workflows to operationalize these services. Unfortunately, smaller organizations do not have the resources to do this as smoothly.
- While CMS may view these services as high value, that perception is not shared by SGIM members and other physicians. SGIM is in the process of updating its Choosing Wisely recommendation regarding annual health checks to state “Don’t perform routine annual checkups unless patients are likely to benefit; the frequency of checkups should be based on individual risk factors and preferences.” This recommendation is based on a recent systematic review of the relevant evidence.7 We also note practical concerns with

the associated administrative burdens of documentation and co-pay collection. For instance, HCPCS code G0439, the subsequent Medicare annual wellness visit, is valued less than CPT code 99397 for general preventive services or CPT 99215 the highest-level outpatient E/M service. CPT code 99397 is not covered by Medicare Part B, but is covered by most Medicare Advantage plans, making it a viable option in many cases. To increase utilization by Medicare beneficiaries for whom an annual checkup is likely to have value, CMS may need to explore Increasing the valuation or reducing the documentation requirements for these services.

- Regarding the behavioral health integration services, cognitive assessment and care, and intensive behavioral therapy services, there are shortages of providers, time, and resources available to bill for these services. Not only are there not enough primary care physicians to deliver these services, but there is a shortage of additional providers, such as psychiatrists, counselors, psychologists, and clinical social workers. SGIM believes that a multispecialty clinic is required to perform these services; however, many clinics, particularly those that are small or located in rural and underserved areas, do not have the staff, time, or resources necessary to bill these services.

- SGIM members have also reported difficulty in referring patients in underserved communities to cardiac rehabilitation services, due to the lack of available providers offering these services.

**SGIM recommends that CMS remove barriers to improve access to these services, including reducing documentation burden and providing operational flexibility for organizations and institutions.** This will help to decrease burden and allow these services to be offered by more physicians. We welcome the opportunity to provide further expertise and continue this discussion with the agency.

**New Coding and Payment for General Behavioral Health Integration (BHI) Billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs)**

SGIM appreciates CMS’ continued commitment to improving Medicare beneficiaries’ access to high quality mental health services, particularly now as the demand continues to grow. General internists and other primary care providers regularly serve as an entry point for patients to the mental health system. Policies that support better integration between the primary care and mental health systems are critical to supporting whole person health care, particularly since primary care physicians are typically responsible for patients’ longitudinal care. While SGIM members will not financially benefit from this change, we believe this represents an important change to improve access to and the integration of mental health services for SGIM’s patient population. **SGIM urges CMS to finalize this code and associated payment as proposed.**

**Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs**

SGIM recommends CMS finalize its proposal to increase rates for methadone payment and the individual therapy component of non-drug bundled payments. Additionally, we support the
proposals to allow buprenorphine initial treatment to be furnished through audio-video technology, and audio-only when audio-video is unavailable and all other requirements are met, past the end of the PHE.

CMS requested comment on performing periodic reassessments virtually. These reassessments are no more complex than initial assessments, and thus are equally appropriate for audio-video and audio-only care. Until a time when digital redlining practices are ended and digital equity is achieved, such that all persons have access to broadband internet, the devices required to use audio-video technology, and the support services to ensure digital health literacy, audio-only options for care remain critical for providers serving rural and other disadvantaged beneficiaries. Black patients are more likely to receive methadone while white patients are more likely to receive buprenorphine. During the PHE, CMS’ policy to temporarily allow audio-video and audio-only care for patients receiving buprenorphine was critical to support opioid use disorder (OUD) treatment but excluding methadone only exacerbated inequities in care stemming from practices and policies that are biased and racist in nature. CMS has made significant strides in improving equity in recent years, and SGIM urges the agency to continue this trend by allowing equal treatment of patients receiving methadone versus buprenorphine. Concerns of safety risk with methadone has led to the decades-old limitation to methadone access stemming from the Narcotic Addict Treatment Act of 1974 (P.L. 93-281), which regulated methadone for OUD to come from OTPs, thereby limiting critical OUD treatment that could come from primary care physicians to combat the opioid epidemic. SGIM members practice in OTPs, but predominantly in primary care, and have felt the limitations of this policy for decades. SGIM acknowledges that CMS does not have the authority to change this ill-founded law, but urges CMS to revise its policy to allow for methadone treatment from OTPs to be furnished through telehealth services, thereby taking a critical additional step towards equity in OUD treatment and expansion of OUD services. Regarding naltrexone, there is no potential for unsafe misuse nor diversion concerns. SGIM urges CMS to allow care surrounding naltrexone prescriptions to be furnished via telehealth services without delay.

SGIM strongly urges CMS to apply the audio-video and audio-only flexibilities to patients receiving methadone and naltrexone, for initial and subsequent periodic reassessment.

Medicare Shared Savings Program
CMS proposed new policies to better promote health equity in the Medicare Shared Savings Program (MSSP). SGIM shares the agency’s goal of improving health equity in the Medicare program and urges the agency to finalize many of these changes to the MSSP.

Advanced Investment Payments
SGIM supports the proposals to incentivize new ACOs to care for vulnerable communities and populations through advanced investment payments (AIPs). CMS requested comments regarding specific/alternate methodologies for calculating payments. SGIM has previously called

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8 https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2732871
9 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764663
for the use of neighborhood/census-based indices as an initial method for accounting for social risk and supports the proposed use of the Area Deprivation Index (ADI) as an alternative method to solely relying on dual-eligible status, which has known limitations including being an insensitive measure of poverty and having different state-based standards. At present, the optimal methods for evaluating and accounting for social risk have not yet been determined. As such, SGIM supports using multiple approaches to account for social risk to be most sensitive in capturing at-risk beneficiaries. **SGIM supports CMS’ proposed alternative methodology to assign a risk score of 100 if either the beneficiary is dual-eligible, or receives a Part D low-income subsidy, or to use the ADI percentile if neither of the above apply.**

**Health Equity Adjustment for ACOs Serving a High Proportion of Underserved Beneficiaries**

SGIM also applauds the proposals to create a health equity adjustment to the MSSP quality performance score. While SGIM acknowledges the rationale for incentivizing/requiring report of all-payer quality measures to qualify for the health equity adjustment, as well as the rationale for the performance scaler to apply the equity adjustments (such that any ACOs performing in the lowest third across all measures would not receive any adjustment), SGIM would support policies in which ACOs serving the highest proportion of underserved beneficiaries would receive a health equity adjustment regardless of performance, similar in concept to the complex patient bonus in MIPS.

CMS requested comments regarding the methodology proposed for the underserved multiplier. SGIM supports the proposal to use a threshold of 85th percentile of ADI, consistent with the literature reporting that health systems caring for the most vulnerable beneficiary populations were more likely to be financially penalized under prior programs. In this instance, SGIM again recommends that until there is a research base demonstrating the most effective ways to account for social risk, using multiple approaches to be most sensitive in capturing risk is appropriate. **As such, SGIM again supports the CMS proposed alternative methodology by which dual-eligible status, the Part D low-income subsidy, and ADI above 85th percentile would all be accounted for. SGIM specifically proposes a methodology by which the multiplier, ranging from zero to one, would be based on the proportion of the ACO’s performance year beneficiaries that meet ANY of the three criteria. This would allow for the most sensitive capture of high social risk, while not “double counting” based on overlapping risk factors.**

**Screening for Social Drivers of Health**

SGIM supports the creation of equity-specific quality measures, including screening for social drivers of health in the MSSP and the Quality Payment Program. However, additional steps would be needed to ensure such a measure would lead to meaningful change. Screening for social drivers would be for the purpose of addressing and improving such drivers, in part through connection to and partnership with community-based organizations. Thus, a more comprehensive set of measures and incentives is needed, such as measures evaluating referral rate and completion rate for receiving services after positive screens; whether the ACO has conducted a community health needs assessment—similar to non-profit hospitals—and acted

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upon assessment findings; and assessing the level of community partnerships. Plans to implement successful aspects from models such as the Innovation Center’s Accountable Health Communities would be critical. SGIM also supports the use of standardized tools in collecting social risk data and screening for drivers of health. As such topics can be sensitive, conducting these screens through trusted, longitudinal care team members is critical, yet balancing this with additional burden and time is challenging, as this would largely fall to primary care-oriented fields which are already overburdened, underpaid and facing workforce shortages. Additionally, a disproportionate share of positive screens requiring follow-up does and would continue to fall on safety-net systems, which face additional financial challenges. As such SGIM supports the need for financial support and adequate training to accompany creation of new equity-focused quality measures, including fair and evidence-based valuation of E/M services as discussed previously, and additional acknowledgement of the time and resources required to meaningfully screen and act upon positive screens.

SGIM would also support such measures being added to foundational layers of the Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs), thus acknowledging that these fundamental equity and social drivers of health issues should be the responsibility of all health care providers. Additionally, some specific challenges arise for use of such measures for small practices within MIPS as opposed to ACOs – small rural practices may not have adequate services to refer to upon positive screens. If such services are not available, screening and identifying positive results without any possible action available may cause at best wasted time, and at worst moral distress and distrust. Therefore, integration with social services is a critical part of increasing the focus on screening for social drivers of health. SGIM has previously published position statements regarding the physician role in addressing social determinants of health\(^\text{11}\), and social risk and equity in Medicare’s value-based programs\(^\text{12}\), and would welcome the opportunity to engage in further discussion with CMS.

**Changes to the Quality Payment Program**

SGIM agrees with the continued emphasis CMS is placing on equity within QPP, including having equity-related measures be considered “high priority” measures, new Improvement Activities pertaining to equity, and the discussion of screening for social drivers of health discussed above.

Improving equity within MIPS has been a longstanding priority of SGIM’s. We have specifically focused on ensuring the agency acknowledges that safety net practices are disproportionately penalized in MIPS and finding ways to appropriately account for social risk. SGIM was pleased to see the temporary increase in the complex patient bonus in CY 2022 and supports CMS continuing this policy in CY 2023. However, SGIM strongly urges CMS to do more to address social risk in MIPS. In contrast to MSSP, where CMS is proposing to use ADI and potentially other measures to better account for social risk in both advanced payments to attract more ACOs to

\(^{11}\) https://link.springer.com/article/10.1007/s11606-020-05934-8

care for underserved populations, and adding an equity adjustment to quality scores, CMS has not proposed substantial policy changes to MIPS to improve equity in this proposed rule.

SGIM respectfully requests that CMS make the following changes:

- Distinguish between medical complexity and social drivers of health to create a specific adjustment for social risk and social drivers of health in the complex patient bonus.
- Implement methods beyond dual-eligible status to account for social drivers of health. Dual-eligible status, while a useful and predictive measure, is insensitive in determining poverty and social risk, and is especially problematic in non-Medicaid expansion states. Incorporation of ADI and the Part-D low-income subsidy, as SGIM supports as alternative methodology in MSSP, would allow broader capture of social risk and more equitable MIPS scoring and payment policy.

The optimal methods for accounting for social risk have not yet been determined, and therefore, SGIM recommends that CMS continue to update policy for accounting for social risk as research in this area emerges. Specifically, the optimal magnitude of the complex patient bonus has not yet been established. As CMS is aware and incorporated into prior policy changes, previous research identified that the previous complex patient bonus was of insufficient magnitude and design to achieve its stated goals of leveling the playing field for those practices and systems caring for vulnerable populations. Increasing the magnitude and changing the methodology to apply to those caring for the highest proportion of vulnerable beneficiaries were important steps that SGIM applauds CMS for making in previous rulemaking cycles. However, these methods continue to need refinement. SGIM has previously suggested peer grouping as per the Hospital Readmissions Reduction Program to ensure practices and systems caring for populations facing similar levels of challenges regarding social drivers of health are fairly compared. SGIM acknowledges that complex patient bonuses or equity adjustments to quality measure performance can also achieve the desired goal, so long as the research base exits to determine the optimal magnitude of bonus. Until then, peer grouping would ensure apples to apples comparisons of quality.

Thank you again for the opportunity to provide comments on this proposed rule. SGIM welcomes the opportunity to work with the agency to achieve the administration’s goal to create a more equitable health care system that results in improved accessibility, higher quality, affordability, and innovation. Should you have any questions, please do not hesitate to contact Erika Miller at emiller@dc-crd.com.

Sincerely,

LeRoi Hicks, MD, MPH
President, SGIM
APPENDIX A

Proposal to Form an Expert Panel to Review Evaluation and Management Services

Request:
The Cognitive Care Alliance (CCA), representing over 60,000 physicians from seven cognitively focused specialty societies, proposes that the Centers for Medicare & Medicaid Services (CMS) convene an expert panel to develop recommendations on how to appropriately define, document, and value evaluation and management (E/M) services.

Background/ Statement of Need:
SGIM thanks CMS for finalizing significant changes to the outpatient E/M services in the CY 2020 Medicare Physician Fee Schedule (MPFS) that will become effective January 1, 2021. We believe these changes are an important first step to appropriately value cognitive work and should be implemented as finalized. The deficiencies in the E/M coding structure and values have resulted in cognitive workforce shortages and limited Medicare beneficiary access to certain primary care and cognitive services. The principal architect of the Resource-Based Relative Value Scale (RBRVS), Dr. William Hsiao from Harvard University, clearly stated that the development of the E/M portion of the MPFS was not adequately supported and that more refinement was needed.13

Changes to the outpatient E/M services are being implemented at a time when the practice of medicine looks significantly different than it did when the RBRVS was established. Now CMS spends approximately $100 billion on MPFS services. Forty percent of that spending is on E/M services - the outpatient E/M services account for 27 percent of MPFS spending. Since the late 1980s, the methodologies of health services research have evolved, the principles of representative databases have been firmly established, methods of adjustment to reflect the influences of health, social, economic, geographic and other factors are more robust, and the unintended consequences of the existing pricing mechanisms have become more clear.14 All of these factors provide CMS with new tools to value cognitive work.

CMS' revisions to the outpatient E/M services have been lauded by the member societies of the CCA and by most of the medical community, yet our societies continue to express concern that these changes do not address the legacy mis-valuation of E/M services. Most importantly, the agency must sustain its commitment to fully understand the resources and work required to deliver cognitive E/M services in both outpatient and inpatient settings, including the expertise demanded to manage the “complexity density” of each encounter, and to accurately define and value service codes that capture current medical practice.

The CCA has called on CMS to conduct research to better understand the components, inputs, interactions, outputs, and implications for all E/M services. We propose that CMS create an expert panel with the express purpose of establishing a permanent mechanism to ensure that the relative valuation of physician services is data driven and reflects the current practices of medicine to achieve the best possible outcomes for all Medicare beneficiaries. Again, this panel would not delay or change the E/M payment reforms finalized in the CY 2020 MPFS. Rather, this panel would assist CMS to ensure that cognitive work is accurately defined and valued under the MPFS.

Proposed Panel Charge, Responsibilities and Composition:

Charge
Using an evidence-based approach, the panel will assess the current definitions, documentation expectations and valuations of existing E/M services and develop a set of recommended changes to address identified data gaps and/or inadequacies.

Responsibilities

- **Evaluate and summarize** the current data and research related to E/M services.
- **Review** the current methodologies and procedures used to define and value services under the MPFS.
- **Identify** the specific knowledge gaps including parameters for additional data needs and research required to study key topics and answer key questions, including:
  - Does the existing E/M code set adequately define and describe the full range of E/M services?
  - If adequate, are the current values for E/M services appropriate? Are the gradations of valuation aligned with the gradations of service intensity?
    - Do they appropriately account for all input elements that contribute to the intensity of work valuation, including the development and maintenance of cognitive expertise, the complexity of the clinically relevant interactions among individual patient characteristics, diagnoses and therapeutics, and the risks and implications that arise from different levels of encounter intensity?
    - Are the existing code definitions clear and accurate? If so, then code definitions should be reviewed to ensure linkage to definable auditing metrics.
  - If inadequate, what changes to the E/M service codes or additional codes are needed to address the possible deficiencies noted above?
Collaborate with the Office of the National Coordinator for Health Information Technology (HIT) to ensure that documentation requirements are easily integrated in the electronic health record (EHR).

Consider and research the development of guidelines for the future relative valuation of physician services. Propose a process whereby CMS can ensure that the MPFS is based on accurate and updated service code definitions, including service code times, and a reliable process of relative valuation based on data collected from patients, physicians, enterprises, and institutions.

- Assess the utility of data describing E/M services from current resources, including the National Ambulatory Medical Care Survey (NAMCS), the Medical Expenditure Panel Survey (MEPS), de-identified Medicare payment data, and de-identified electronic health record data sources.

- **Develop** new valuation concepts, if warranted, to capture the breadth and value of E/M services and determine how these can be best integrated in with existing RBRVS.

- **Recommend** changes, if warranted, that should be made to the current E/M code set to ensure the valuations of these codes reflect current medical practice.

- **Oversee the development of and provide input for** any new E/M services including:
  - service descriptions,
  - billing and coding guidelines, and
  - program integrity requirements

**Panel Composition**
To ensure diverse perspectives are factored into the development and refinement of E/M services, membership should include:

- Clinicians, such as general practice and specialty medicine physicians, and other qualified health professionals;
- Medicare Beneficiaries;
- Health economists and health services researchers.
- Experts in medical coding and code valuation;
- Health informatics experts;
- Experts in program integrity and compliance;
- Stakeholders with expertise in Medicare payment policy.

**Cognitive Care Alliance Member Organizations:**
- American Society of Hematology
- Infectious Diseases Society of America
- Society of General Internal Medicine