November 23, 2022

The Honorable Chuck Schumer
Majority Leader
United States Senate
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
United States House of Representatives
1236 Longworth House Office Building
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
317 Russell Senate Office Building
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
2468 Rayburn House Office Building
Washington, DC 20515

Dear Majority Leader Schumer, Speaker Pelosi, Leader McConnell, and Leader McCarthy:

The Society of General Internal Medicine (SGIM) joins with all other physician professional organizations urging Congress to take action to address the Medicare payment cuts, which are set to take effect January 1, 2023. The SGIM appreciates your efforts last year to prevent the Medicare Physician Fee Schedule (MPFS) conversion factor and PAYGO cuts that were scheduled to take effect in 2022; however, physicians again are facing payment cuts of approximately 8.5 percent in 2023.

For these reasons, we strongly urge you to address the impending payment cuts and work to bring stability to the Medicare payment system to end this cycle of threatened cuts and legislative fixes. To most effectively accomplish this, we urge Congress to address two concurrent but interacting issues: (1) the anticipated cut to Medicare payment; and (2) ensure a reliable, evidence-based, and publicly accountable process for establishing the definitions and values for physician services within the 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. Below, we wish to elaborate on the challenges facing our country’s physician workforce and the need for a broader agenda.

Congress Must Mitigate the Medicare Payment Cuts Expected on January 1, 2023

Specifically, Medicare physician payment will be reduced by two factors on January 1, 2023:

- A 4.5 percent cut to the MPFS conversion factor, which is the result of the expiration of the 3 percent increase to the MPFS authorized by Congress in the Protecting Medicare and American Farmers from Sequester Cuts Act coupled with the required budget neutrality adjustments.
A 4 percent across the board cut to the Medicare program as a result of the passage of the American Rescue Plan Act, which increased the federal budget deficit over a 10-year period triggering a statutory reduction as required by the Pay-As-You-Go Act of 2010. In the Protecting Medicare and American Farmers from Sequester Cuts Act, Congress delayed this mandatory cut until 2023.

Without Congressional intervention, these payment cuts will impact Medicare beneficiaries’ access to patient care and jeopardize the sustainability of medical practices around the country. Physicians and practices are still grappling with COVID-19-related challenges and increased costs due to inflation at the same time they are expected to withstand an 8.5 percent Medicare cut. Moreover, plans for improved access to health care, addressing health disparities, dealing with current and future pandemics, and meeting the aspirational goal of greater value from health care expenditures will be at risk. Therefore, the SGIM strongly recommends that Congress work in a bipartisan manner to avert these cuts before the end of the year.

Congress Must Ensure the Accuracy and Reliability of Medicare’s Physician Payments
SGIM believes that the valuations of physician services within the MPFS must be accurate, reliable, evidence-based, and accountable to deliver the best outcomes for all Medicare beneficiaries and a balanced physician workforce. SGIM members primarily provide evaluation and management (E/M) services to our patients. SGIM has urged the Centers for Medicare and Medicaid Services (CMS) to develop an evidence-based approach to address and improve the definitions and valuations of E/M services, so they better reflect the complex work of our members. However, CMS has not established a formal process to incorporate evidence-based data into the valuation process of E/M service codes.

To provide background, since 1992, the MPFS has priced all services provided to Medicare beneficiaries relative to one another according to the paradigm of the Resource-based Relative Value Scale (RBRVS). Physicians are paid in relative value units (RVUs), which when multiplied by the conversion factor, yields the actual Medicare allowable dollar payments. The total payment includes the work, practice expense (i.e., infrastructure, supplies, personnel, etc.), and malpractice costs associated with each individual service. Importantly, when Congress established a fee schedule with fixed pricing based on the relatively of the services provided, there was no complementary directive that CMS establish an internal and transparent process for maintenance of the MPFS. Thus, the SGIM’s consistent advocacy for improvements in the determination of the work component of Medicare service code valuations is rooted in our belief that relativity of values among service codes has not been adequately maintained over the last 30 years.

Unfortunately, the longstanding underpricing of non-procedural physician services, such as E/M services, has led to a skewed workforce, impaired access to health care services, and exacerbated health disparities. According to the Health Resources and Services Administration’s (HRSA) workforce projections, the supply of primary care providers, including general internists,
is projected to increase from 2018-2030, yet continues to lag projected demand during the same time period.\textsuperscript{1} Data from the American Association of Medical Colleges corroborates this data projecting a primary care physician shortage of between 17,800 and 48,000 by 2034.\textsuperscript{2} These estimates, however, may be optimistic as they do not account for the effects the COVID-19 pandemic may have on the physician workforce.

Now, more than ever, it is time to comprehensively review and improve the processes that CMS uses to establish MPFS physician services and payment. To elucidate, CMS recently implemented improvements to the outpatient and inpatient E/M code valuations and documentation requirements, which resulted in the first significant changes to these codes in 30 years. These changes were overdue and necessary to ensure the codes represented the current state of medical practice and improve the health outcomes of Medicare beneficiaries. However, due to the long period between review of these services and the statutory requirement that all changes to the fee schedule be budget neutral, the updates to E/M codes, which make up a significant portion of MPFS spending, have created profound disruptions across the fee schedule.

To prevent similarly large conversion factor decreases and redistribution of RVUs within the MPFS, the SGIM proposes the establishment of an expert panel to serve in an advisory capacity to CMS. We believe an expert panel will not only prevent large payment decreases, but it will serve an important role in ensuring MPFS services are appropriately valued using the best available data to reflect the complexity of care delivered. An expert panel, providing an independent assessment of available data and recommendations to CMS, 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 workforce. The expert panel would be empowered to collect its own survey data and could work closely with the American Medical Association Relative Value Scale Update Committee (RUC) in doing so. Importantly, survey data collection would necessarily become more representative since current RUC surveys, in many cases, are not broadly representative. Given the central role of the MPFS in the pricing of all health care professional services, having an accountable and transparent process that is evidence based is long overdue.

Above all, SGIM envisions a panel charged with developing recommendations on how to appropriately define and value E/M services. We maintain that CMS must utilize the best data, metrics, and analytic tools for the determination of relative valuations within the Resource-based Relative Value Scale and ensure that physician services are accurately valued on a more regular basis. We urge you to authorize an expert panel in any legislation to mitigate the upcoming Medicare payment cuts. Our expert panel proposal and draft authorizing language are included in the attached Appendix.

Thank you for the opportunity to provide these comments. We appreciate your leadership and steadfast efforts to protect Medicare beneficiaries’ access to care. We welcome the opportunity

\textsuperscript{1} https://data.hrsa.gov/topics/health-workforce/workforce-projections
\textsuperscript{2} https://www.aamc.org/media/54681/download?attachment
to meet with you to discuss our comments further. Please direct any questions to Michaela Hollis at mhollis@dc.crd.com.

Sincerely,

[Signature]

LeRoi Hicks, MD, MPH
President, Society of General Internal Medicine

cc: Chairman Ron Wyden, Senate Finance Committee
Ranking Member Mike Crapo, Senate Finance Committee
Chairman Richard Neal, House Ways & Means Committee
Ranking Member Kevin Brady, House Ways & Means Committee
The Honorable Debbie Stabenow
The Honorable John Barrasso, MD
The Honorable Robert Menendez
The Honorable Roger Marshall
The Honorable Jacky Rosen
The Honorable John Boozman
The Honorable Gary Peters
The Honorable Shelley Moore Capito
The Honorable Kirsten Gillibrand
The Honorable Bill Cassidy, MD
The Honorable Raphael Warnock
The Honorable Rand Paul
The Honorable Kyrsten Sinema
The Honorable Charles Grassley
The Honorable Chris Van Hollen
The Honorable Kevin Cramer
The Honorable Tammy Duckworth
The Honorable Lisa Murkowski
The Honorable Mark Kelly
The Honorable Cindy Hyde-Smith
The Honorable Angus King
The Honorable James Risch
The Honorable Jon Tester
The Honorable Cynthia Lummis
The Honorable John Hickenlooper
The Honorable Thom Tillis
The Honorable Sherrod Brown
The Honorable Marsha Blackburn
The Honorable Alex Padilla
The Honorable James Lankford
The Honorable Christopher Coons
The Honorable Josh Hawley
The Honorable Catherine Cortez Masto
The Honorable Marco Rubio
The Honorable Thomas Carper
The Honorable James Inhofe
The Honorable Edward Markey
The Honorable Susan Collins
The Honorable Elizabeth Warren
The Honorable Amy Klobuchar
The Honorable Richard Blumenthal
The Honorable Jeanne Shaheen
The Honorable Dianne Feinstein
The Honorable Joe Manchin
The Honorable Mazie Hirono
The Honorable Tina Smith
APPENDIX A

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

Request:

The Cognitive Care Alliance (SGIM), representing over 33,000 physicians, 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. 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. 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 SGIM 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 SGIM 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

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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
APPENDIX B
SEC. 1. EVALUATING EVALUATION AND MANAGEMENT SERVICES

(a) ESTABLISHMENT. —There is established an ad hoc committee to be known as the “Evaluation and Management Services Review Committee” (referred to in this subsection as the “Committee”).

(b) MEMBERSHIP. —

(i) NUMBER AND APPOINTMENT. —The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

(ii) QUALIFICATIONS. —The membership of the Committee shall include individuals with national recognition for their expertise in the delivery of care in general internal medicine and the internal medicine subspecialties, medical coding and code valuation, health services research and Medicare payment policy. No more than 5 members of the Committee shall be providers of services or representatives of providers.

(iii) PROHIBITION ON FEDERAL EMPLOYMENT. —A member of the Committee shall not be an employee of the Federal Government.

(iv) ETHICS DISCLOSURE. —The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(v) DATE OF INITIAL APPOINTMENTS. —The initial appointments of members of the Committee shall be made by not later than 180 days after the date of enactment of this subsection.

(c) TERM; VACANCIES. —

(i) TERM. —The terms of members of the Committee shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(ii) VACANCIES. —Any member appointed to fill a vacancy occurring before the expiration of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

(d) DUTIES.—The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, on the valuation of evaluation and management and related services by evaluating the current data and research related to evaluation and management services; reviewing the current valuation methodologies; identifying specific knowledge gaps including parameters for additional data needs and research required to study key topics to properly value these services; develop new valuation concepts, if warranted, to capture the breadth and value of evaluation and management
services; recommend changes to the evaluation and management code set to ensure
their valuation reflects current medical practices; and oversee development and provide
input for any new evaluation and management services.

(e) COMPENSATION OF MEMBERS. —

(i) IN GENERAL. —Except as provided in clause (ii), a member of the Committee
shall serve without compensation.

(ii) TRAVEL EXPENSES. —A member of the Committee shall be allowed travel
expenses, including per diem in lieu of subsistence, at rates authorized for an
employee of an agency under subchapter I of chapter 57 of title 5, United States
Code, while away from the home or regular place of business of the member in
the performance of the duties of the Committee.

(f) OPERATIONAL AND TECHNICAL SUPPORT. —

(i) IN GENERAL. —The Assistant Secretary for Planning and Evaluation shall provide
technical and operational support for the Committee, which may be by use of a
contractor. The Office of the Actuary of the Centers for Medicare & Medicaid
Services shall provide to the Committee actuarial assistance as needed.

(g) FUNDING. —The Secretary shall provide for the transfer, from the Federal
Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are
necessary to carry out this paragraph.

(h) APPLICATION. —Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall
not apply to the Committee.