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Admiral Rachel L. Levine, MD, FAAP
Assistant Secretary of Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 716G
Washington, DC 20201

Judith Steinberg, MD
Senior Advisor, Office of the Assistant Secretary of Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 716G
Washington, DC 20201

Dear Admiral Levine and Dr. Steinberg:

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to respond to this request for information on the Department of Health and Human Services (HHS) Initiative to Strengthen Primary Care (the Initiative). SGIM is a member-based internal medical association of more than 3,000 of the world’s leading academic general internists, who are dedicated to improving the access to care for all populations, eliminating health care inequities, and enhancing medical education.

SGIM was a co-sponsor of the National Academies of Sciences, Engineering and Medicine (NASEM) report titled Implementing High Quality Primary Care: Rebuilding Foundation of Health Care and is pleased this report will inform the development of HHS’ initial plan on primary care and future actions for the Initiative. As such, we wish to elaborate further on certain topics of importance to our members and their patients relevant to three of the four categories of comments requested: 1) Successful models or innovations that help achieve the goals for primary health care; 2) Barriers to successful models or innovations; and 4) Proposed HHS actions.

1. **Successful models or innovations that help achieve the goals for primary health care:**

As HHS already recognizes, primary care is the foundation of a strong health care system, which has been demonstrated repeatedly in the literature. Despite the evidence it improves health outcomes and equity, the incentives and infrastructure have not been put in place to allow primary care to deliver on its promise. Below are programmatic examples of programs and infrastructure required that if scaled could help to fulfill primary care’s promise.

- While primary care should be at the center of a high performing health care system, interprofessional collaborations and handoffs are essential, particularly when treating high-risk patients with conditions like diabetes, chronic liver disease, cancer, or heart failure. Virtual platforms are a valuable tool to optimize care and handoffs for these patients, and should be recognized and reimbursed appropriately.

- Improving health outcomes and equity requires support of primary-care-based strategies that occur outside of face-to-face visits with primary care physicians and other health care professionals. Programs that address social determinants of health, including food and housing insecurity, are critical to support and improve individuals’ health outcomes. The Fruit and Vegetable Rx Program for Patients with Food Insecurity, which has been deployed
in high needs populations in Georgia, is one example of how to address these patients’ needs successfully.¹

- The Maryland Primary Care Program Management Office developed the HEART Payment Playbook in conjunction with the Centers for Medicare & Medicaid Services (CMS) to provide additional support to address the complex needs of socioeconomically disadvantaged populations as defined by the area deprivation index and high Hierarchical Condition Category (HCC) risk scores.²

2. Barriers to implementing successful models or innovations:

- CMS has recently adopted increases to the relative value units (RVUs) for the outpatient evaluation and management (E/M) services, is proposing to increase the RVUs of certain inpatient E/M and observation services and has paid for new services to support care coordination and transitions of care. Despite these positive changes, primary care remains undervalued. The budget neutral nature of the Medicare Physician Fee Schedule limits the impact of these improvements as the increases are eroded over time. Additionally, the structure of the American Medical Association’s Relative Value Scale Update Committee, the primary vehicle for valuing physician services, poses additional challenges to proper valuation of primary care and other cognitive work.

- SGIM is deeply concerned about primary care workforce shortages, particularly in rural areas. 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.³ 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 2034.⁴ These estimates may be optimistic as they do not account for the affects the COVID-19 pandemic may have on accelerating physician retirements or the number of primary care physicians in concierge practices. True health care system transformation cannot be achieved without a primary care workforce that reflects the diversity of the population.

- Graduate medical education (GME) for which Medicare is a major public funding source is central to the development of a robust, well-trained workforce. According to a Congressional Budget Office estimate, total federal spending for GME in 2018 was more than $15 billion, of which roughly 80 percent or approximately $12 billion was financed by Medicare.⁵ Pressure to achieve long-term economic stability in health care and growing concern that the United States does not match medical training with national needs has prompted calls for a redesign of GME residency programs that improves future access to and delivery of health care services.

³ https://data.hrsa.gov/topics/health-workforce/workforce-projections
⁴ https://www.aamc.org/media/54681/download?attachment
⁵ https://www.cbo.gov/budget-options/54738
• SGIM is strongly committed to advancing health services research in primary care as supported by the Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Outcomes Research Institute (PCORI); however, the federal government has not made the investments in the research needed to support development and continuing improvement of innovative primary care models.

• The lack of integration of primary care research into communities, public health agencies, and other sectors is a barrier to improving the primary care system. SGIM recommends that AHRQ’s National Center for Excellence in Primary Care Research (NCEPCR) facilitate this integration with an emphasis on addressing social determinants of health and disparities in health and health care.

4. Proposed HHS actions

SGIM recommends that HHS use the Initiative to address the barriers in payment, the workforce, and research addressed in these comments. Specifically, we request that HHS consider the following policy changes:

Payment Recommendations:
• SGIM recommends that the Initiative support a transition to hybrid and prospective payments to better support primary care consistent with NASEM Action 1.2. To capture the full spectrum of primary care work, HHS, CMS, and the Initiative need to understand the work required and value of the individual component primary care services, a longstanding priority of SGIM. The Society believes that implementing evidence-based payment policy in the determination of relative valuations will support patient access and a balanced physician workforce, and is consistent with NASEM’s Action 1.3 directing CMS to increase the overall portion of spending going to primary care.

• Hybrid and prospective payments, not fee-for-service alone, can best capture the work performed and services delivered in a high-performing primary care system. Therefore, the Initiative should undertake an effort to develop payments based on the relativity of work intensity by establishing a reliable process for defining services and assigning values as the existing mechanisms are not evidence based and have helped perpetuate the system that has not prioritized primary care. HHS should establish an expert panel to be administered by CMS to assess the existing processes for service code development and valuation and propose solutions that are sustainable, and evidence based. Additionally, HHS and CMS should use existing databases, like the National Ambulatory Medical Care Survey and the Medical Expenditure Panel Survey, to assess the impact of payment policy on patient access. These recommendations are all consistent with NASEM Action 1.3.

• Consistent with NASEM’s first objective - pay for primary care teams to care for people, not doctors to deliver services - federal programs must support the appropriate reimbursement for team-based primary care in addition to reimbursing primary care physician services appropriately using evidence-based data. Care teams should include pharmacists, mental health professionals, and social workers to meet all the needs of complex patients.

• While access to high quality primary care in and of itself has been shown to improve equity, payment policy must also specifically promote equity. HHS must ensure that all value-based
models account for social risk to ensure safety nets are not unfairly penalized and to incentivize expanding successful value-based models to marginalized communities. SGIM has detailed immediate and long-term steps to do this in its position statement on Social Risk and Equity in Medicare’s Mandatory Value-Based Payment Programs.  

Workforce/Education Recommendations:

- SGIM believes an evidence-based mechanism should be developed and implemented to bolster the workforce both by growing and retaining the primary care physician workforce. Additionally, AHRQ has indicated it plans to make investments to support an expanded primary care outcomes research workforce. These investments must include fellowship-level training and career development awards for young investigators with a particular commitment to increasing the diversity of the workforce. These recommendations are consistent with NASEM’s third objective to train primary care teams where people live and work.

- SGIM recommends sustained, robust funding for the HRSA Title VII programs, which aim to improve the supply, distribution, and diversity of the primary care workforce and train the next generation of health professionals to meet our nation’s demanding health care needs. Programs like this should be replicated where appropriate and given the support necessary for them to function as diversifying the professionals who work in the health and social service sector is critical to reducing health disparities. HRSA has experience in increasing diversity in professional training programs and could also serve as a resource and partner to other agencies.

- SGIM recommends developing a payment structure for GME that supports primary care, is transparent, holds teaching institutions accountable for their training outcomes, and results in a highly trained, appropriately distributed workforce well-equipped to meet the nation’s health care needs. As outlined in SGIM’s White Paper, “Addressing the Nation’s Physician Workforce Needs,” we recommend the need for accurate workforce needs assessment, broadened GME funding sources, increased transparency of the use of GME dollars, and implementation of incentives to increase the accountability of GME-funded programs for the preparation and specialty selection of their program graduates. Furthermore, the number and specialty distribution of available GME positions shapes the overall composition of our national workforce. As the country’s population continues to age and we experience a growing incidence in chronic disease, we must see an increase in funding for Medicare GME-funded training positions that reflects the physician workforce needs of the nation.

Research Recommendations:

- SGIM urges HHS to invest in AHRQ and PCORI funded research and programs to support primary care as part of the Initiative.

- SGIM recommends that HHS and the Initiative support AHRQ’s NCEPCR to enhance the quality, effectiveness, and value of care while addressing health care disparities and the care of underserved populations.

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• AHRQ has invested in telehealth programs and research. SGIM urges more research be supported in this space to improve the quality of care associated with increased use of telemedicine as this has the potential to both improve health outcomes as well as mitigate the primary care physician shortage.

SGIM is deeply committed to strengthening the country’s primary care system and improving the health of all Americans. Again, we appreciate the opportunity to provide these comments and welcome the opportunity to partner with you. Should you have any questions or require further information, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

LeRoi Hicks, MD, MPH
SGIM President