September 11, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P)

Dear Administrator Brooks-LaSure:

The Society of General Internal Medicine (SGIM) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) proposed rule. SGIM is a member-based internal medical association of more than 3,000 of the world's leading academic general internal medicine physicians, who are dedicated to improving the access to care for all populations, eliminating health care inequities, and enhancing medical education. Our members are committed to delivering high quality care and ensuring patients have access to a well-trained physician workforce. Therefore, the policies in this proposed rule are important to our members who provide care for Medicare beneficiaries.

We appreciate your consideration of our comments on the following sections of the proposed rule:

- Conversion Factor for 2024
- Evaluation and Management (E/M) Visits
- Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology
- Payment for Medicare Telehealth Services
- Services Addressing Health-Related Social Needs

Conversion Factor for 2024

The conversion factor for 2024 is set to decrease by approximately 3.36% from $33.8872 to $32.7476. We recognize that this decrease is the result of a statutory 0% update scheduled for the MPFS, a negative 2.17% relative value unit (RVU) budget neutrality adjustment, and the expiration of funding Congress added to the MPFS for 2023. These cuts will have a detrimental impact on general internal medicine physicians, potentially jeopardizing their ability to provide quality care to Medicare beneficiaries. The shortages of general internal medicine and other primary care physicians are well documented, and the stagnation of Medicare physician

payment for the last 20 years has only perpetuated this shortage as medical residents choose more lucrative specialties and those perceived to be less stressful. SGIM recognizes that CMS does not have the statutory authority to mitigate these cuts and address these issues on its own. However, without a significant change, more Medicare beneficiaries will experience challenges accessing comprehensive primary care. **We will be working with Congress to address this issue and recommend that the agency do so as well.**

Evaluation and Management (E/M) Visits

Office/Outpatient E/M Visit Complexity Add-on Implementation

SGIM urges CMS to implement the complexity add-on code G2211 as proposed after its implementation was delayed by Congress for three years. We agree with CMS that the complexity add-on code reflects the time, intensity, and practice expense involved when practitioners furnish the kinds of office/outpatient E/M office visit services that enable them to build longitudinal relationships with all patients (not only those patients who have a chronic condition or single high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time.

G2211 is necessary to support the resources required to maintain continuous patient care. As internal medicine specialists practicing primary care, SGIM members are aware of the resources required to maintain access between a patient and a physician between visits. Providing payment for G2211 reflects the resources required to support longitudinal care outside of the time spent and services provided on the calendar day of a face-to-face visit beyond what is captured by the current E/ M service codes and, most importantly, the infrastructure required to maintain a continuous relationship with each individual patient.

SGIM members offer the following additional examples of the types of services that general internal medicine physicians often deliver between visits for their complex patients:

- Patients with insulin dependent diabetes have symptoms and other needs that require attention between visits, such as glucose monitoring, medication management, assistance with supplies, and coordination with other clinicians, often requiring multiple complex decisions between visits.
- Patients generate numerous additional questions that may be more straightforward, such as whether to get the COVID vaccine, or how to manage the transition from one formulary to another, the volume of which can be substantial.
- Clinicians often liaise with other members of the health care team between visits, such as case managers, behavioral health specialists and community health workers (CHWs). CHWs, for example, may need to address issues such as transportation barriers that prevent a patient from keeping their medical appointments. Physicians need to work closely with behavioral health workers to ensure proper pharmacotherapy for mental health conditions. Case managers keep in touch with patients and physicians between visits to spot decompensation early before the illness becomes too acute to necessitate a visit to the emergency room.

- Primary care clinicians often provide care coordination for patients seeing multiple physicians for specialty care. Ironically, although surgical specialties have questioned the need for G2211, we have found over the last decade that much of this care coordination is for post-operative questions. The complexity of this coordination and need for physicians with longitudinal relationships with patients is well described by Matthew Press in his perspective article, "Instant replay – a quarterback's view of care coordination,"[1] and others[2].

SGIM supported the increased RVU valuations of the outpatient E/ M service code families implemented by CMS as well as G2211 when it was first proposed for CY 2021. While we are grateful that CMS increased the values of outpatient E/M services based on a survey of the Relative Value Scale Update Committee (RUC), we fully agree with the agency that the values for the revised outpatient E/M codes did not fully account for the physician work and resources associated with the delivery of longitudinal, patient-centered care to complex patients, regardless of the outpatient E/M visit level, provided by general internal medicine physicians and internal medicine subspecialists.

G2211 must be implemented to compensate for the time, resources, and costs involved in chronic disease management and the maintenance of longitudinal patient-doctor relationships. As the agency has recognized, these resources and work are separate from those included in services like complex care management and transitional care management, and are part of the relationships physicians and patients develop over time. Reliable access and sustained communication are essential for the development of patient-doctor trust.

SGIM believes that G2211 is necessary for the future of primary care. Ultimately, we fully support a detailed examination of the processes and outcomes used to define end price physician services. G2211 will serve as a bridge until E/M services can be properly valued to fully capture the work of general internal medicine physicians. **Therefore, we urge the agency to finalize the implementation of G2211.**

Request for Comment About Evaluating E/M Services More Regularly and Comprehensively
SGIM applauds CMS for including this request for comment about evaluating E/M services more regularly as the proper definition and valuation has been a longstanding concern of the Society. Despite the proposal to implement G2211, we do not believe that the current outpatient and other E/M service codes reflect the work and resources required to deliver non-procedural and cognitively intense care to Medicare beneficiaries.

Based on the questions posed, the Society believes that CMS recognizes the fundamental differences between procedural and non-procedural work. Over the last 30 years, with a doubling of procedural services, the Medicare Part B dollars available for primary care services

[1] Press MJ. Instant replay--a quarterback's view of care coordination. *N Engl J Med*. 2014 Aug 7;371(6):489-91. doi: 10.1056/NEJMp1406033. PMID: 25099572.
[2] Stange KC. The generalist approach. Ann Fam Med. 2009 May-Jun;7(3):198-203. doi: 10.1370/afm.1003. PMID: 19433836; PMCID: PMC2682975.

within the MPFS declined to such a low level that the difference in top to bottom salary range between those physicians who provide primary care and those physicians who provide procedures is currently two or more-fold.

SGIM is a professional organization with many who are deeply committed to peer reviewed health services research, and we feel the time has come to ensure that the fee schedule is based on the best knowledge available. From the very first implementation of the MPFS based on the Resource-Based Relative Value Scale (RBRVS), there has been no agency level commitment to ensure that both the definition and valuation of physician services are based on the best evidence possible, that the determination of relativity has internal checks and balances, and that the entire process is publicly accountable.

- Do the existing E/M HCPCS codes accurately define the full range of E/M services with appropriate gradations for intensity of services?

The recent changes to the outpatient E/M services were the first substantive changes to the definition and valuation of these services since the implementation of the RBRVS. These revisions were an important first step toward appropriately valuing E/M care; however, more must be done to properly define and value these services. Despite the changes CMS Implemented in 2021, the outpatient E/M codes retain the same five-level structure that was developed when the RBRVS was implemented in 1992. Over three decades ago, the principal architect of the RBRVS, Dr. William Hsiao from Harvard University, clearly stated that the development of the E/M portion of the MPFS was not adequately supported by empiric research. At that time, he called for more refinement. As structured, the most recent revisions of E/ M service code definitions and valuations have not remedied the original problems and fail to capture the intensity of E/M care, particularly the care provided to Medicare beneficiaries with one or more complex comorbid conditions. For example, patients with diabetes, chronic kidney disease and hypertension, which are frequently present together, require a complex and precise medication regimen, with routine laboratory monitoring, home blood pressure and blood sugar monitoring, frequent dose adjustments, and frequent counseling. Physicians must be able to update treatment plans and guide patients based on lab results, home readings, and medication side effects, all of which occur between routine visits. Under the current E/M system, this additional time is not accounted for outside of the day of the service visit.

- Are the methods used by the RUC and CMS appropriate to accurately value E/M and other HCPCS codes?

SGIM feels that fundamental problems with the outpatient and other E/M codes will not be solved by the existing processes employed by the Current Procedural Terminology (CPT)® Editorial Panel and the American Medical Association (AMA) RUC. Both groups played a significant role in the recent revisions to E/M services, which did not address the underlying problems with these service codes.

While we understand that the physicians who serve on the RUC are not representing their specialties, we believe that there is an expertise bias on the RUC toward procedural care based on the panel's composition. This bias influences the process of how services are valued. Additionally, the RUC survey process, while flawed, captures quantifiable data about procedures. Unfortunately, the value of the non-procedural care delivered by general internal medicine physicians and internal medicine subspecialists is much harder to quantify in a survey. A significant portion of the value of E/M and other non-procedural services lies in the physicians' skills and expertise in diagnosing and managing complex conditions, coordinating care, considering the patient's overall health and well-being, and making treatment decisions that consider various factors beyond just the face-to-face interaction between the physician and patient. As the agency aptly points out when discussing mental health services, cognitively intense work only increases over time. These are factors that will not be accurately captured by looking at time or intensity using intraservice work per unit time, commonly referred to as IWPUT.

Additionally, SGIM remains concerned that the RUC process is closed, particularly when CMS accepts upwards of 90% of their recommendations as in this year's proposed rule. SGIM does not have a seat in the AMA House of Delegates and has no way to participate in the process because many of our members choose not to pay the expensive dues required to join the AMA. We are not the only specialty society unable to participate in the process by either serving on the panel or having an advisor observe and participate in the process.

- Are the current non-E/M HCPCS codes accurately defined?
- Are the methods used by the RUC and CMS appropriate to accurately value the non-E/M services?

SGIM believes that these questions raise a more profound question: Do physicians who provide mostly procedures understand the complexity of work of those physicians who use their depth and breadth of knowledge to deliver comprehensive care in longitudinal relationships with patients? The origins of the RBRVS trace back to the 1980s when Medicare faced an uncertain financial future because physicians were billing widely different charges that varied enormously for the same service. Given the necessity to have a national fee schedule, the RBRVS processes worked successfully. Arguably, non-E/M services may be sufficiently defined and then valued through existing processes, such as those governed by the CPT Editorial Panel and the RUC. We defer to those who deliver non-E/M services to assess how well the codes represent the work performed. However, both the definition and valuation of non-E/M services must be based on the best evidence available and be periodically reviewed and publicly accountable.

- What are the consequences if services described by HCPCS codes are not accurately defined?
- What are the consequences if services described by HCPCS codes are not accurately valued?

The longstanding misvaluation of E/M services within the MPFS has led to a skewed workforce and has impaired access to care for Medicare beneficiaries. Many SGIM members work as medical educators. We have witnessed a noticeable effect of low E/M service code valuation on our students' and residents' likelihood of choosing a career in general internal medicine and other primary care specialties. With large medical debt, they are drawn to more highly compensated specialties.

Our country is facing a primary care tipping point. The recent report from the National Academies of Sciences, Engineering, and Medicine, presents a comprehensive case for a robust and sustainable primary care workforce.[3] This seminal work must not be ignored. American exceptionalism applies in other domains, but when it comes to health care, the insufficient dedication to establishing and maintaining a primary care workforce results in increased costs due to systemic inefficiencies and worse health outcomes compared to other developed countries.

We fully acknowledge the current federal commitment to primary care access. Training programs have been operative for years but despite the federal government's investment, the workforce shortage is growing and is gaining public attention.[4] While there have been calls to protect the primary care workforce, not enough has been done. Importantly, the primary care workforce demographic is starting to age out and the pipeline is nearly dry. There are areas of the country where some patients cannot access general internal medicine or other primary care physicians. This is particularly pronounced in underserved communities and safety net hospitals, where disparities and access issues are becoming more pronounced. If Medicare is going to lead the way in addressing longstanding disparities of access, changes must be implemented.

Improving the definitions and valuations of E/M services alone will not solve the primary care conundrum. However, there will be no improvement without changes. Revisiting the definitions and valuations of E/M services is the only meaningful way that CMS can address these shortages and ensure equitable access to care for all Medicare beneficiaries.

To accurately define and value non-procedural E/M services, SGIM continues to recommend the implementation of an expert panel. SGIM recognizes that Congress directed CMS to provide an update in the fiscal year (FY) 2024 Congressional Justification on a process to evaluate E/M services more regularly and comprehensively in the report accompanying the FY 2023 omnibus appropriations bill.[5] SGIM advocated for this language and believes that an expert panel will ensure that the definitions and valuations of all E/M services are accurate and reliable. Additionally, an expert panel will be best equipped to ensure that these services are evaluated at more regular intervals, limiting the significant redistributive effects associated with major

[3] https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care
[4] Rosenthal E. The shrinking number of primary-care physicians is reaching a tipping point. The Washington Post. September 5, 2023. Opinion | The lack of primary-care physicians is reaching a tipping point - The Washington Post.
[5] https://www.appropriations.senate.gov/imo/media/doc/Division%20H%20-%20LHHS%20Statement%20FY23.pdf

valuation and policy changes as we saw when the outpatient E/M codes were revalued after almost 15 years. We believe that a regular, independent assessment of available data and the resulting data-driven policy recommendations will stabilize what has evolved to become an irregular process, one which has been a major contributor to the declining primary care workforce.

SGIM's proposed expert panel would be charged with using an evidence-based approach to assess the current definitions, documentation expectations, and valuations of existing E/M services, and develop a set of recommended changes to address inadequacies of service code definitions and valuations. With expertise from a variety of stakeholders, the panel's responsibilities would include:

(1) evaluating and summarizing current data and research related to E/M services;
(2) reviewing current methodologies and procedures used to define and value services under the MPFS;
(3) identifying knowledge gaps;
(4) developing new valuation methods and guidelines, if warranted; and
(5) recommending changes to the current E/M code set.

The panel should also collaborate with the Office of the National Coordinator for Health Information Technology to ensure that documentation requirements are easily integrated into the electronic health record.

Moreover, to ensure diverse perspectives are factored into the development and refinement of E/M services, SGIM believes panel membership should have a transparent process for managing conflicts of interest and include:

- clinicians, particularly 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;
- experts in health informatics technology;
- experts in program integrity and compliance; and
- other stakeholders with expertise in Medicare payment policy.

As envisioned, this panel is meant to inform the work of CMS and not intended to eliminate or exclude existing processes by which professional societies participate in CPT coding decisions and the RUC. The output of the expert panel would be publicly available.

While out of CMS' control, budget neutrality undoubtedly poses a major challenge to the proper valuation of E/M services. It ensures that there will always be tension between procedural and non-procedural physicians, particularly in an environment when overall physician payment has failed to keep pace with inflation and practice expenses over the last 20 years. SGIM will be

working to address this with Congress but recognizes that adding money to the fee schedule will be challenging. Our advocacy will be much stronger if we can assure Congress that the processes used by CMS to define and price services are reliable and accurate.

Split/Shared Visits

SGIM supports the agency's proposal to maintain the current definition of "substantive portion," which allows for the use of either one of the three components—history, exam or medical-decision making (MDM)—or more than half of the total time spent to determine the provider that will bill for the visit. We recommend that the agency continue to allow for billing by MDM or time for these services as this represents usual practice patterns and will reduce the burden on providers and be more consistent with the rest of the E/M code families. When using MDM as a determinate for billing, SGIM recommends that CMS implement clear requirements for demonstrating that the billing provider, either the physician or non-physician practitioner, implemented their own critical thinking and planning. As CMS continues to collect information from stakeholders on these services, SGIM welcomes the opportunity to work together to ensure that any changes promote team-based care and reflect accurate practice patterns in medicine.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology

Last year, CMS finalized a policy to rebase and revise the Medicare Economic Index (MEI) to reflect current market conditions in providing physician services. However, after receiving comments on this issue, and considering the AMA's plans to launch a new Physician Practice Information Survey (PPIS), CMS has again delayed implementation of the rebased MEI data in MPFS rate setting for CY 2024. SGIM supports CMS' decision to delay any changes to practice expense inputs. **Once CMS does implement updates to practice expense inputs, SGIM recommends that CMS implement these changes over a four-year period to prevent large distributive effects of these changes to the fee schedule.**

In the interim, we appreciate that CMS is continuing to solicit public comment on strategies to update practice expense data collection and methodology that account for changes in the health care landscape. SGIM remains concerned that CMS does not have a system to ensure that practice expense inputs remain current. As we recently witnessed, failure to update clinical labor practice expense inputs for well over a decade resulted in significant redistributive effects in the budget neutral MPFS and created challenging conditions for many physicians who saw their reimbursement decrease as a result. Medicare Part B reimbursement has failed to keep pace with inflation; however, physician practices must pay competitive wages to their staff and the market rate for supplies and equipment. For these reasons, CMS must evaluate and update practice expense inputs on a more regular basis to prevent these discrepancies and provide greater stability to physician payment. **We recommend that CMS implement a process for ensuring that staff, supply, and equipment inputs are updated on a regular basis, potentially every five years.**

Payment for Medicare Telehealth Services

Direct Supervision Definition and Supervision of Residents in Teaching Settings
SGIM is pleased that the agency proposes to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024, to align with the extension of other telehealth flexibilities. Additionally, SGIM thanks CMS for allowing teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, through audio/video real-time communications technology, for all residency training locations through December 31, 2024. **While we urge that these proposals be finalized as proposed, SGIM strongly recommends that CMS extend these flexibilities to be available on a permanent basis.**

These flexibilities are another important tool to expand access to care, particularly in shortage specialties like general internal medicine. Virtual supervision will continue to sustain clinical capacity and support equity, as many teaching sites deliver care to vulnerable populations who may face challenges accessing necessary care. Our members, many of whom serve as the primary internal medicine faculty of medical schools and major teaching hospitals in the United States, have found that teaching models continue to evolve and incorporate remote supervision into practice while maintaining safe and high-quality care. Given the growing shortage of general internal medicine physicians, this flexibility is critical to ensuring Medicare beneficiaries have access to comprehensive primary care.

CMS Proposal to Add New Codes to the Telehealth List
CMS proposes to add HCPCS code GXXX5 (Administration of a standardized, evidence-based Social Determinants of Health (SDOH) Risk Assessment tool, 5-15 minutes) to the telehealth list. **SGIM supports this proposal, and we address the proposed creation of this code in the following section.**

Services Addressing Health-Related Social Needs
SGIM supports the CMS proposal to pay separately for Community Health Integration (CHI), SDOH Risk Assessment, and Principal Illness Navigation (PIN) services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. Through these proposals, CMS recognizes the vital role played by these professionals and the need for a team-based, comprehensive approach to health care delivery.

CHI Services
SGIM appreciates that CMS is taking steps to recognize the valuable services that community health workers (CHWs) provide when assisting Medicare beneficiaries with services not typically reimbursed on the MPFS. **We urge CMS to finalize the proposal to create two new HCPCS codes to describe services performed by "certified or trained auxiliary personnel, which may include a CHW, incident to the professional services and under the general supervision of the billing practitioner."**

SGIM members work with CHWs regularly and have described the benefit they bring to patient care. At some health centers, SDOH screening is standardized. Based on the patients' screening results, CHWs have the capacity to provide targeted support and resources for patients. Therefore, we appreciate that CMS has recognized the valuable contributions of CHWs and for working to ensure that these services are recognized and reimbursed accordingly.

- Should CMS consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for CHI services?

SGIM urges CMS to broaden the initiating visit for CHI services beyond E/M visits to include annual wellness visits and targeted behavioral health codes, such as psychiatric diagnostic evaluation and health behavior assessment codes, 90791 and 96156. Additionally, we urge CMS to consider including E/M visits from emergency department (ED) visits and inpatient/observation visits when the beneficiary already has an existing, longitudinal primary care physician. These would help prevent delays to CHI services and would help reduce unnecessary administrative burden on primary care physicians. When beneficiaries have established longitudinal relationships with primary care physicians and new SDOH risk factors are identified, primary care physicians routinely provide care outside of standard offices visits to expedite meaningful care. As per our discussion of the G2211 code above, this care is frequently done between E/M visits and is not reimbursed. However, primary care physicians still perform the care, and do not always need interval E/M visits. Consider an example at an integrated medical center:

> *A patient has diabetes and heart failure that is managed by the primary care physician. Since the last clinic visit, the patient has lost her job, and can no longer afford healthy foods, and has relied more heavily on cheaper, processed, high-sodium foods. As a result, she has increased edema and mild shortness of breath and presents to the emergency room. The ED physician, who is frequently the first to know of patients with social stressors, adeptly identifies the underlying cause of her heart failure exacerbation, documents the new SDOH risk factor and appropriate Z59.41 code for food insecurity, and refers for CHI services. The ED physician treats the mild exacerbation with intravenous diuretics and discharges the patient safely home. The primary care team is alerted, and the next day the team nurse calls the patient to check-in, and she is breathing well. She has a scale for home monitoring of her weight and volume status. She appreciates the referral for CHI services to help with food insecurity. The primary care physician is alerted, who reviews the chart and recommends a higher dose of the patient's oral diuretic until she can resume a healthier, lower-sodium diet, and orders follow-up lab tests for the following week. CHI services begin immediately. The patient is supported through her challenging life circumstances and is able to find healthier food options to keep her heart failure stable.*

In this example of high quality, team-based primary care, coupled with the benefits of integrated care across the health system, such a patient may not need a primary care E/M visit to initiate the CHI services. A future primary care E/M visit would undoubtedly be warranted, but with the shortage of primary care physicians, it could take weeks, which would delay meaningful services for the patient, leading to repeat ED visits, higher cost, worse health outcomes, and poor patient-centered care. In other circumstances, a primary care E/M appointment might be necessary to determine the best course of action and make an appropriate CHW referral. **However, SGIM urges CMS not to inadvertently handcuff the benefits of CHI services (and similar PIN services) with too narrow a definition of an initiating visit.**

Regarding "incident to" billing for CHI services, **SGIM requests clarification as to whether these services can be billed at safety-net clinics in academic medical centers**. General internal medicine physicians are the predominant primary care physicians at these clinics, which provide care for the most socially and medically complex patients, who would benefit most from CHI services (as well as the other two services as per below). Our understanding is that incident-to billing for CHI services under the supervision of primary care physicians at these safety-net clinics would not be allowed. SGIM recognizes the complex issues around facility fees and the push toward site-neutral payments for hospital outpatient departments. Regardless, safety-net clinics at academic medical centers are not profiteering from facility fees, and SGIM believes that excluding them from using these newly proposed codes would be antithetical to the purpose of these proposed changes and detrimental to the patients we serve. **Thus, SGIM urges CMS to consider ways for such clinics and the patients served by these clinics to benefit from these new codes.**

Lastly, SGIM asks CMS to reconsider the exclusion of home health patients from receiving CHI services. Home health services are more clinical in nature, and do not overlap substantially with CHI services. SGIM members care for many patients who would benefit from both types of services.

SDOH Risk Assessment

SGIM recommends that CMS finalize the policy to add HCPCS code GXXX5 to the MPFS. Factors related to a patient's SDOH can significantly influence a patient's health outcomes and their ability to follow through with medical recommendations. The new G-code recognizes the additional time and resources that general internal medicine physicians spend assessing SDOH factors that could impact a patient's treatment. SGIM members who work in safety net hospitals believe that this code could be billed for most patient visits, particularly when treating patients who are experiencing homelessness and low-income people. However, we request clarification from CMS on the documentation requirements for billing this code, and what if any additional documentation is required beyond International Classification of Disease 10 Z-codes. SGIM cautions CMS from including overly burdensome documentation requirements for this code.

While we appreciate CMS' proposal for the creation of GXXX5, we want to make sure that this new code is implemented in a way that achieves CMS' goal to improve screening and documentation of SDOH data in the medical record. SGIM is concerned that over the past

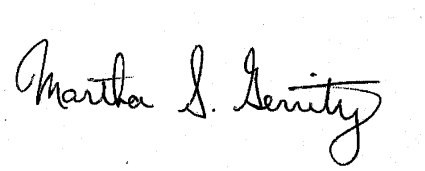
decade CMS has created codes targeted to primary care providers and patient access to primary care services and many of these codes have experienced low uptake. The advanced care planning services are a good example of this.[6] SGIM members believe that these services impose significant documentation burden. Consequently, physicians and institutions have opted to not integrate these services, deeming the effort required for compliance and documentation requirements outweighs the potential benefits. While the advanced care planning services are one example, our members are experiencing similar challenges and constrained utilization in relation to the principal care management and chronic care management codes as well. Therefore, SGIM welcomes the opportunity to work with CMS to ensure that the documentation requirements for GXXX5 are not overly burdensome to ensure high uptake and spread among providers.

PIN Services

SGIM supports CMS' proposal to create HCPCS codes and payment to describe PIN services associated with the care of patients with a "serious, high-risk disease expected to last at least 3 months, which places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/ decompensation, functional decline, or death." CHWs and other auxiliary personnel are already performing these activities to identify and connect patients with appropriate clinical and support resources. For example, a CHW may help to provide transportation for a patient to get to the ER. This in turn saves utilization costs and reduces back-end costs for the patient so they do not receive a large ambulance bill. **Therefore, SGIM urges CMS to finalize coding and payment policies to support this work.**

Thank you for the opportunity to provide these comments. SGIM looks forward to working with you to ensure that Medicare beneficiaries have access to high quality and affordable care. Should you have any questions about our comments, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,



Martha S. Gerrity, MD, MPH, PhD, FACP
President, Society of General Internal Medicine

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7440514/