



OFFICERS

Martha Gerrity, MD, MPH, PhD, FACP
Portland, OR
President

Jada Bussey-Jones, MD, FACP
Atlanta, GA
President-Elect

LeRoi Hicks, MD, MPH
Wilmington, DE
Past-President

Arleen F. Brown, MD, PhD, FACP
Los Angeles, CA
Secretary

Patrick G. O'Connor, MD, MPH
New Haven, CT
Treasurer

Elizabeth A. Jacobs, MD, MPP
Scarboro, ME
Treasurer-Elect

COUNCIL MEMBERS

Vineet Chopra, MD, MSc
Denver, CO

Elizabeth Dzung, MD, PhD, MPH, MPhJ
San Francisco, CA

Marshall Fleurant, MD
Atlanta, GA

Cristina M. Gonzalez, MD, MEd
New York, NY

Wei Wei Lee, MD, MPH
Chicago, IL

Brita Roy, MD, MPH, MHS
New Haven, CT

EX-OFFICIO

Thomas Radomski, MD
Pittsburgh, PA
Chair, Board of Regional Leaders

Joseph Conigliaro, MD, MPH
Oyster Bay, NY
Co-Editor
Journal of General Internal Medicine

Michael D. Landry, MD, MSc
New Orleans, LA
Editor, SGIM Forum

Mohan M. Nadkarni, MD
Charlottesville, VA
President
Association of Chiefs and Leaders
of General Internal Medicine

Kay Ovington, CAE
Alexandria, VA
Deputy Chief Executive Officer

Eric B. Bass, MD, MPH, FACP
Alexandria, VA
Chief Executive Officer

October 4, 2023

The Honorable Jason Smith
Chair
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

SUBMITTED ELECTRONICALLY VIA WMAccessRFI@mail.house.gov
Re: Addressing Chronic Disparities in Access to Health Care in Rural and Underserved Communities

Dear Chair Smith:

The Society of General Internal Medicine (SGIM) is pleased to provide these comments in response to your request for information on improving access to health care services in rural and underserved areas. 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. As such, we are pleased to share these comments, which address policies to ensure all Americans have access to high-quality, patient-centered primary care.

Health Care Workforce

SGIM is deeply concerned about primary care workforce shortages as we believe primary care is the foundation of a strong healthcare system. There are many areas of the country where patients cannot access general internal medicine physicians who have special expertise in meeting the primary care needs of adults with complex medical conditions, and other health professionals who provide complementary primary care services, such as general pediatricians and family physicians. This is particularly pronounced in rural and underserved communities and safety net hospitals, where disparities and access issues are becoming more pronounced.

A recent report published by the National Association of Community Health Centers shows that nearly one-third of the nation does not have adequate access to a primary health care clinician due to a shortage of providers in their community.¹ Additionally, according to the Health Resources and Services Administration's (HRSA) workforce

¹ https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf



projections, the supply of primary care physicians, including general internal medicine physicians, is projected to be insufficient to meet demand in 2035.² Data from the American Association of Medical Colleges corroborates this, projecting a primary care physician shortage of between 17,800 and 48,000 by 2034.³

SGIM recognizes and appreciates the current federal commitment to primary care access. However, despite the federal government's investment, the workforce shortage is growing and gaining public attention.⁴ While there have been calls to protect the primary care workforce, not enough has been done and there is a need for broad policy change. SGIM was a proud co-sponsor of the National Academies of Sciences, Engineering and Medicine (NASEM) report titled [Implementing High Quality Primary Care: Rebuilding Foundation of Health Care](#). The report highlights the need for better education, training, and support for the primary care workforce to improve patient access and health equity.

The Medicare Graduate Medical Education Program (GME) is a major public funding source that 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.

SGIM's vision for GME reform addresses the nation's physician workforce needs and provides viable options to ensure patient access to care. **We recommend that the Committee work to develop 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. Specifically, Congress must ensure that any increase in GME slots include dedicated slots for specialties with well-documented shortages, like internal medicine, family medicine, and pediatrics.** Increasing GME slots without specific policy to address shortages will perpetuate the primary care workforce shortage. As the country's population continues to age and we experience a growing prevalence of chronic diseases, Congress must increase funding for Medicare GME funded training positions, particularly for primary care physicians training in internal medicine, family

² <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/Primary-Care-Projections-Factsheet.pdf>

³ <https://www.aamc.org/media/54681/download?attachment>

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.cbo.gov/budget-options/54738>



medicine, or pediatrics, to best reflect the physician workforce needs of the nation. **SGIM also recommends that the federal government support a comprehensive and ongoing workforce needs assessment, broadened GME funding sources, and implementation of incentives to increase the accountability of GME-funded programs for the preparation and specialty selection of their program graduates.**

SGIM recognizes that the Health Resources and Services Administration (HRSA) falls outside the purview of the Committee's jurisdiction; **however, we strongly encourage the Committee to support HRSA workforce and training programs, such as the Teaching Health Center GME (THCGME) program and the Title VII Health Professions Training programs, and replicate programs like these across the federal government.** Federal physician workforce training programs play a critical role in addressing these challenges. The THCGME program is designed to support the training of residents in primary care training programs in community-based patient care centers, which prepare these residents for careers in which they provide high quality care in rural and underserved communities. In academic year 2021-2022, the THCGME program strengthened the primary care workforce by supporting 38 family residency programs, eight internal medicine residency programs, and three pediatrics programs.⁶ However, more funding is necessary to support additional residency programs and residents. Additionally, the program must be reauthorized for fiscal year 2024, and there is a need for a permanent reauthorization to ensure greater stability and secure access for rural and urban medically underserved individuals.

Furthermore, SGIM recommends sustained, robust funding for the HRSA Title VII programs that have a long history of supporting primary care physicians training in internal medicine, family medicine, and pediatrics, and providing health care to communities with limited access to care. These programs improve the supply, distribution, and diversity of the primary care workforce and train the next generation of health professionals to meet our nation's growing health care needs. Specifically, the Title VII workforce diversity programs, including the Centers of Excellence and Health Careers Opportunity Program, are crucial in increasing representation of underrepresented minorities in the health professions. The Primary Care Training and Enhancement and Medical Student Education program support a workforce that delivers comprehensive primary care services, which has been proven repeatedly to lead to more equitable health outcomes, lower costs, and better-quality care.^{7,8,9} **SGIM recommends**

⁶ <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/teaching-health-center-graduate-medical-education-annual-report-2021-2022.pdf>

⁷ <https://www.healthaffairs.org/content/forefront/primary-care-investment-key-improving-population-health-and-reducing-disparities>

⁸ <https://pubmed.ncbi.nlm.nih.gov/30776056/>

⁹ <https://pubmed.ncbi.nlm.nih.gov/20439859/>



that Congress examine opportunities for replicating programs like the HRSA Title VII program to ensure that our healthcare workforce is made up of professionals with diverse backgrounds. This is critical to reducing health disparities as true health care system transformation cannot be achieved without a primary care workforce that reflects the diversity of the population.

Sustainable Provider and Facility Financing

Without Congressional intervention, Medicare beneficiaries' access to care is threatened by the Medicare Physician Fee Schedule's (MPFS) flawed reimbursement mechanism. As proposed in the Calendar Year (CY) 2024 MPFS rule, the conversion factor is set to decrease by approximately 3.36% from \$33.8872 to \$32.7476. 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. This proposed cut is not the first of its kind; given the lack of positive updates and budget neutrality requirements, physicians have been facing reimbursement cuts for the last several years.

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. Without significant change, more Medicare beneficiaries—regardless of where they live—will experience challenges accessing comprehensive primary care. **Therefore, we urge Congress to add an inflationary adjustment to the MPFS, as is included in other Medicare fee schedules, to ensure that Medicare physician payment keeps up with inflation.**

While this will be an important first step to improve the MPFS, additional changes are required to ensure all Americans are able to develop and maintain longitudinal relationships with general internal medicine and other primary care physicians. Our members primarily bill evaluation and management (E/M) services, which are also referred to as office visits. In 2021, the Centers for Medicare & Medicaid Services (CMS) implemented the first substantive changes to outpatient E/M services since the implementation of the Resource Based Relative Value Scale (RBRVS) over 30 years ago. 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 these changes, the outpatient E/M codes retain the same five-level structure that was developed when the RBRVS was established 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 further 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 paid for beyond the limited reimbursement included in the day of the service visit.

Without equitable reimbursement, CMS and Congress will not be able to address the primary care workforce shortage and ensure there is an adequate supply of general internal medicine and other primary care physicians. 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) Relative Value Scale Update Committee (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 when they were recently reviewed.

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.¹⁰ 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 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.

¹⁰ <https://www.appropriations.senate.gov/imo/media/doc/Division%20H%20-%20LHHS%20Statement%20FY23.pdf>



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:

- evaluating and summarizing current data and research related to E/M services;
- reviewing current methodologies and procedures used to define and value services under the MPFS;
- identifying knowledge gaps;
- developing new valuation methods and guidelines, if warranted; and
- 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.

Unless and until CMS and Congress take a different approach to defining and valuing office visits, Medicare beneficiary access to high-quality, patient-centered primary care will be threatened and those in rural underserved areas will be particularly challenged to access care. **Therefore, SGIM urges this Committee to support the creation of an expert panel to define and value E/M services. When these services are reimbursed more appropriately, general internal medicine and other primary care disciplines will become more attractive career paths for medical residents.**



Innovative Models and Technology

SGIM appreciates that the Committee is interested in expanding innovative care models and technology. Based on members' experiences during and since the COVID-19 public health emergency, we believe that preserving access to telehealth services is critical to ensuring Medicare beneficiaries receive the health care services they require, particularly in rural and underserved areas where primary care physicians and specialists may be in short supply.

Telehealth

SGIM is deeply appreciative of the actions Congress has already taken to extend the waiver of the originating site and geographic restrictions, extend the ability of Federally Qualified Health Centers and Rural Health Clinics, and coverage of audio-only services through December 31, 2024, in the *Consolidated Appropriations Act, 2023* (P.L. 117-328). **We recommend that these policies be made permanent to ensure all Medicare beneficiaries are able to access medically necessary care.** Our members' experiences over the last three plus years demonstrate that telehealth and audio-only services can be delivered successfully to patients in their homes and other locations outside of originating sites and may improve access and compliance. The expansion of telehealth services has been particularly impactful for Americans who live in rural and underserved areas and cannot easily travel to a physician's office.

Telehealth can play a critical role in improving access to health care services for all Americans. It has decreased the likelihood for patients to delay care until they can attend an in-person visit or seek care in emergency settings, both of which may require patients to travel significant distances. By permanently eliminating the originating site and geographic restrictions, we can better prevent health complications and worsened health conditions that become more complex and expensive to treat. This flexibility benefits patients who are unable to take time off from work, arrange transportation, or afford childcare or elder care.

The ability to deliver audio-only services has been extremely important for Medicare beneficiaries, especially those living in rural areas, who lack access to high-speed broadband or the technology necessary for video visits. Through audio-only E/M visits, SGIM members have successfully managed various chronic diseases, including but not limited to diabetes and hypertension. Eliminating this flexibility will limit access to care for some of the most vulnerable Medicare beneficiaries. **Therefore, SGIM strongly recommends Congress act to authorize the coverage of audio-only care on a permanent basis.**

SGIM recognizes that all virtual visits do not incur the same costs for space, supplies, and staff as in-person visits do. However, practices must make significant investments in the adoption and maintenance of telehealth equipment and software, and these visits



require significant staff time to deliver high-quality, safe care for patients. Despite the extension of certain telehealth flexibilities, many of the institutions where our members practice have prioritized in-person care, which will undermine access for certain patients. We were pleased that CMS proposed to retain payment parity between in-person and virtual services in the CY 2024 MPFS proposed rule and expressed our strong support for this policy. **We recommend that Congress do the same to preserve access to virtual services.**

Prior Authorization

In regard to increasing administrative burden, SGIM members routinely encounter the process of prior authorization (PA) in their clinical practice. While we recognize that PA plays an important role in ensuring patients receive medically appropriate care, obtaining PA approval can be a complex and time-consuming process. Our members frequently order imaging tests, such as computerized tomography (CT) and magnetic resonance imaging (MRI) scans in the outpatient setting, to evaluate new symptoms and complaints. Delays in diagnosis may result in the patient requiring an emergency department (ED) visit, whereas timely approval can improve patient outcomes while preventing these unnecessary and costly visits. SGIM members also order durable medical equipment (DME), such as wheelchairs for patients with a diagnosis of a debilitating neurological condition. These orders are subject to complicated approval requirements and may require the physician to schedule a lengthy peer-to-peer meeting prior to approval. Streamlining and improving the inefficiencies of the PA process will help reduce administrative burden on physicians and ensure patients receive timely and appropriate care. **SGIM encourages the Committee to support the implementation of improvements in the PA process to improve health outcomes and prevent increased health costs, including but not limited to, integrating electronic PA process within electronic medical records to limit the creation of more burdensome requirements and implementing specific timeframes and communication requirements for PAs.**

Other Programs

Additionally, SGIM would like to highlight several examples that if scaled would help ensure access to primary care services. Despite the evidence that access to primary care improves health outcomes, the incentives and infrastructure have not been put in place to deliver on that promise. Therefore, these programs that support primary care are critical to improving the health of Americans, including those who may not have regular access to health care services in rural and underserved areas.

Primary care should be at the center of a high performing health care system, and 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.



The Maryland Primary Care Program Management Office developed the HEART Payment Playbook in conjunction with CMS to provide additional support to address the complex needs of socioeconomically disadvantaged populations as defined by high Hierarchical Condition Category (HCC) risk scores and socioeconomically disadvantaged populations as defined by the area deprivation index.¹¹ CMS should consider options for expanding this program.

Thank you for the opportunity to provide these comments on improving access to health care services in rural and underserved areas. Should you require additional information, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

A handwritten signature in black ink that reads "Martha S. Gerrity". The signature is written in a cursive, flowing style.

Martha Gerrity, MD, MPH, PhD, FACP
President

¹https://health.maryland.gov/mdpcp/Documents/MDPCP_HEART_Payment_Playbook.pdf