

**Statement for the Record**  
**From Society of General Internal Medicine**  
**For the Senate Committee on Finance Hearing:**  
***Bolstering Chronic Care through Medicare Physician Payment***  
**Held on April 11, 2024**

The Society of General Internal Medicine (SGIM) thanks the Senate Finance Committee (“the Committee”) for holding this hearing on how to better reimburse physicians and the care teams who deliver chronic care to Medicare beneficiaries and for providing this opportunity to submit this statement for the record.

SGIM is a member-based medical association of more than 3,300 of the world’s leading academic general internal medicine physicians, who are dedicated to delivering high-quality clinical care, improving access 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.

Primary care is the foundation of a strong health care system. Primary care physicians, including general internal medicine physicians, provide a broad range of clinical services and expertise, from preventative healthcare to treatment of multiple chronic medical conditions. In addition, primary care physicians also serve as the coordinator of their patients’ overall care. In this role, they not only coordinate with other physicians, nurses, pharmacists, and social workers within their practice but also specialists, mental health professionals, and laboratories outside of them. They ensure that other care team members understand the patient’s medical history and comorbid conditions and that the decisions being made are patient-centered. Our members take pride in cultivating enduring, trust-based relationships with patients that span decades. However, despite the robust evidence that coordinated primary care improves health outcomes and equity, incentives and infrastructure are not in place to allow primary care to deliver on its promise.

This Committee must develop policies that will support the delivery of patient-centric care to Medicare beneficiaries and bolster the primary care workforce. The shortages of general internal medicine and other primary care physicians are well documented. The inadequate reimbursement for primary care generally and care coordination specifically has only perpetuated this shortage. SGIM members practice at the nation’s medical schools and academic medical centers where they serve as educators and mentors. Therefore, we are ever mindful of the career choices made by students and residents and the influence compensation discrepancies between primary care and procedurally-oriented specialties have on those choices.

Without meaningful change, more patients—regardless of where they live—will experience challenges accessing comprehensive primary care. Primary care practices have been operating on minimal or even negative profit margins in recent years. The financial challenges as well as the long hours and administrative burden associated with the practice of primary care has brought the United States to the point that there is a severe shortage of general internal medicine and other primary care physicians. Without action, these shortages will only grow and become more problematic as the Medicare population ages and their needs for coordinated comprehensive care grow.

The overarching problems facing the Medicare Physician Fee Schedule (MPFS) are making it difficult to enact reforms to support primary care and chronic care delivery. As access to primary care services becomes more challenging, cognitive and procedural specialties are also being

challenged by the downward pressure on Medicare physician payment, which has stagnated over the past two decades without receiving necessary increases or adjustments for inflation or to account for increased costs of providing comprehensive care in stark contrast to other Medicare fee schedules. According to an American Medical Association analysis of Medicare Trustees data, Medicare physician payment has declined by 30% percent when adjusted for inflation from 2001–2024.

Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA) to enable Medicare to pay for high-quality care rather than the volume of services provided. However, this experiment failed. MACRA only authorized 0.5% updates to the conversion factor through 2019. For the last several years, the lack of positive updates and the MPFS' budget neutrality requirements have resulted in cuts to Medicare reimbursement, which Congress has mitigated. While SGIM appreciates Congressional actions to minimize these cuts, the downward pressure on Medicare reimbursement continues and is exacerbated by the MPFS' budget neutrality requirements, which have not been updated since 1992. The budget neutrality threshold, which remains \$20 million, pits specialties against one another. As long as some specialties experience losses when new codes are added to the MPFS or positive updates are recommended for certain services, Congress and the Centers for Medicare & Medicaid Services (CMS) will not be able to transform the MPFS to support the delivery of high-quality coordinated primary and chronic care. Therefore, SGIM urges this Committee to make two structural reforms to the MPFS to support more equitable reimbursement: 1) an annual inflationary update to the conversion factor, and 2) an increase in the budget neutrality threshold to \$53 million from \$20 million with the provision of inflationary updates every five years thereafter. These two changes will help reverse the downward pressure on Medicare physician payment. Making all physicians' reimbursement more sustainable will allow the Committee to make additional changes to support the delivery of high quality primary and chronic care.

The significantly lower payment rates for primary care compared to those for procedural specialties discourage medical students from choosing primary care specialties, as they are attracted to higher-paying specialties particularly considering their growing amounts of medical school debt. As a result, many Americans do not have a primary care physician with whom they can schedule timely visits and receive longitudinal, comprehensive care; instead, they receive care from urgent care clinics and overcrowded emergency rooms. Even those with established primary care physicians have difficulty accessing the appropriate level of care, as primary care physicians are forced to see a higher volume of patients for shorter appointments. This leads to a viscous cycle of either less comprehensive care, or physicians being forced to work after-hours doing uncompensated but critical care coordination, leading to fatigue, burnout and erosion of the primary care workforce. Further, the persistent shortage of primary care physicians nationwide, particularly in rural communities, exacerbates existing disparities among vulnerable populations that are already facing significant healthcare challenges.

CMS has taken steps in recent years to support primary care by creating new services, like those for chronic care management, and revising and revaluing evaluation and management (E/M) services. However, the lack of positive conversion factor increases and budget neutrality adjustments has eroded the value of these reimbursement increases for primary care. SGIM urges Congress to work with us to develop a set of reforms to support primary care and bring stability to the Medicare physician payment system. Specifically, Congress must improve reimbursement for the E/M services that are central to the comprehensive care of patients delivered by primary care physicians. Better reimbursement for these E/M services would also help to support the comprehensive care that many specialists deliver to patients with complex conditions such as diabetes mellitus, congestive heart failure, and kidney failure. Despite recent

efforts to redefine and revalue E/M services, further improvements should be made to support patient-centered care, particularly for Medicare beneficiaries who have one or more chronic conditions.

SGIM believes that establishing a technical advisory committee (TAC) to define and value E/M and other non-procedural work is critical to appropriately reimbursing for primary care services and supporting the delivery of high-quality comprehensive care as outlined in Senator Sheldon Whitehouse's primary care discussion draft. This has been a longstanding priority of our professional society. SGIM believes that Congress should codify CMS' responsibility to ensure that the MPFS is accurate, reliable, and publicly accountable. A TAC could assess the existing processes for service code development and valuation and propose solutions that are sustainable and evidence based.

The TAC can begin making meaningful improvements to reimbursement for primary care now and ensure that the valuations of physician services provide reliable building blocks, which can be used in developing innovative alternative payment models like a hybrid payment system for primary care. Specifically, the TAC can determine how to base payments on the relative intensity of cognitive work by establishing a reliable process for defining services and assigning values. The existing mechanisms for valuing cognitive work are not evidence based and have helped perpetuate a system that has not prioritized primary care, while the volume and value of technical and procedural services has grown. SGIM believes that a TAC is critical to support primary care but recognizes that the existing mechanisms to value MPFS services may be better suited to be applied to procedures. This TAC does not have to replace the existing mechanisms for valuing all MPFS services.

As the population ages, Medicare must lead the way in supporting primary care and other cognitive based care (e.g., addiction treatment and behavioral health). A TAC will incorporate evidence-based data into the valuation process of E/M service codes and be best equipped to ensure that these services are evaluated at more regular intervals. We believe that a regular, independent assessment of available data and data-driven policy recommendations will stabilize what has evolved to become an irregular process, which has been a major contributor to the declining primary care workforce. Even as hybrid and other alternative payment models expand, the importance of proper valuation of E/M services and the critical role of a TAC will remain. Alternative payment models continue to be based on the underlying MPFS, and any payment model must have a strong primary care system as the foundation. Appropriate valuation of primary care will remain critical to ensure resources are appropriately distributed to enable high quality, comprehensive, patient-centered care.

Again, thank you for the opportunity to submit this statement for the record. SGIM looks forward to working with the Committee and the bipartisan working group on physician payment to meaningfully reform the MPFS.