June 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to submit comments on the Senate Finance Committee's ("the Committee") white paper titled "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." SGIM is a member-based medical association of more than 3,300 of the world's leading general internal medicine physicians, who are dedicated to improving 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.

SGIM is deeply appreciative of the Committee's commitment to supporting the delivery of high-quality chronic care and reforming the Medicare Physician Fee Schedule (MPFS). As you understand, primary care is the foundation of a strong health care system. However, despite the robust evidence that primary care improves health outcomes, incentives and infrastructure have not been in place to allow primary care to deliver on its promise. The shortages of general internal medicine and other primary care physicians are well documented, and the inadequate reimbursement for primary care has only perpetuated this shortage. Without meaningful change, more patients—regardless of where they live—will lose access to comprehensive primary care. To save primary care and bolster chronic care delivery, Medicare must do more to support the primary care system that people need.

SGIM recognizes that the overarching problems facing the MPFS make it difficult to enact reforms to save primary and chronic care delivery. As is well documented, Medicare physician reimbursement has stagnated over the past two decades without receiving necessary increases or adjustments for inflation or to account for increased costs of delivering care in stark contrast to other Medicare fee schedules. According to an American Medical Association (AMA) analysis of Medicare Trustees data, Medicare physician payment has declined by 30% when adjusted for inflation from 2001–2024. 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. SGIM strongly believes that the Committee must enact reforms to save primary care while placing the MPFS on a more sustainable trajectory. As such, we are pleased to provide the following comments and look forward to working with you on this important issue.

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Addressing Payment Update Adequacy and Sustainability

As outlined, there has been downward pressure on the conversion factor for the last three decades. The current conversion factor is $33.2875 compared to $31.0010 in 1992. Over the last 20 years, the Medicare Economic Index (MEI), a measure of practice cost inflation, has increased over 50%. This has created an unsustainable situation for physicians with many undesirable consequences, but none as dire as those being experienced by general internal medicine and other primary care physicians. 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 created a serious shortage of general internal medicine and other primary care physicians across the United States. Congress must take immediate action to preserve patients' access to primary care, which is a key piece of a high-performing healthcare system.

The markedly reduced buying power of the conversion factor coupled with the relatively low relative value units (RVUs) for evaluation and management (E/M) services has played a major role in the current workforce shortage by discouraging medical students from choosing primary care specialties, as they are attracted to higher-paying specialties due to their large amounts of medical school debt. As a result of the dwindling primary care pipeline, 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 vicious cycle of either less comprehensive care, or physicians being forced to work extra-long hours doing uncompensated but critically important 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. Therefore, it is imperative for the Committee to address both factors that lower reimbursement for primary care: the conversion factor and the valuation of E/M and non-procedural services.

As recognized in the white paper, CMS has described the MEI as the best measure available of the relative weights of the three components of MPFS payments – work, practice expense, and malpractice. **Therefore, we recommend that Congress provide an annual inflation-based adjustment to the conversion factor equal to the MEI.** While this policy is costly, it places the MPFS on par with other Medicare fee schedules. The MPFS is the only Medicare fee schedule that does not have an inflationary update built into its system, and implementing this update is essential to ensure its long-term sustainability.

Budget Neutrality and the Conversion Factor

The Committee's discussion of the implementation of the Transitional Care Management (TCM) codes highlighted one of the main problems with the MPFS' budget neutrality requirements. This

policy has exacerbated the problems with the MPFS conversion factor by further eroding its value when utilization estimates of services provided under the MPFS are off target. **Therefore, SGIM believes that correcting inaccurate budget neutrality assumptions is an essential improvement to the MPFS' budget neutrality policy.** *The Provider Reimbursement Stability Act of 2023* (H.R. 6371) has been introduced in the House and addresses this issue. It authorizes the Secretary to compare estimated utilization to actual utilization and adjust the conversion factor for over- or underutilization based on the difference. SGIM believes this is a commonsense policy that could be easily implemented to improve conversion factor adjustments.

Additionally, SGIM recommends that Congress revise the outdated budget neutrality threshold of $20 million. The budget neutrality threshold pits specialties against one another because some specialties experience losses when new service codes are added to the MPFS, or when positive updates are recommended for certain services. If this continues, Congress and CMS will not be able to transform the MPFS to support the delivery of high-quality coordinated primary and chronic care. Different updates ranging from $53 to 100 million have been advanced for Congress to consider. SGIM believes that health economists should be consulted to find the appropriate update, which should be indexed for inflation once established. Congress should also provide for an increase every five years equal to the cumulative increase in MEI to ensure that physician payments keep pace with inflation and the cost of delivering care.

Incentivizing Participation in Alternative Payment Models

While SGIM supports the transition to value-based health care, we believe that the longstanding imbalance in the MPFS, which continually undervalues non-procedural physician services, has impacted access to primary care and has slowed the transition to value-based care. SGIM believes that hybrid payment models may be an appropriate transitional step toward value-based care, allowing for some stability of revenue. Currently, health systems are forced to determine how to allocate resources within alternative payment models (APMs) and do so based on the MPFS' distorted reimbursement, undermining the goal of value-based care. Small independent primary care practices and health care systems providing care to underserved communities particularly struggle to stay afloat as they face heavy administrative burdens and inadequate reimbursement.

One key point of reference on this topic is the new Center for Medicare and Medicaid Innovation (CMMI) Making Care Primary (MCP) model that is launching on July 1 of this year. While we have yet to obtain data from this model, its development was informed by lessons and challenges from previous CMMI primary care APMs, and MCP's design offers several innovations that could be considered more broadly even as the program launches. First, MCP offers upfront capacity building payments that are significant in scale and adjusted based on medical and social risk complexity. This feature may lower the barrier of entry for small or rural practices or even larger organizations less experienced with value-based care that would need considerable infrastructure investment to support APMs. The type and scale of risk adjustment also align with CMS' health equity priorities. Second, beyond the upfront capacity-building payments, the per-beneficiary, per-month (PBPM) and performance-based payment structure of MCP may offer a more generalizable template as CMS seeks to support a variety of clinical practices and health systems in moving to APMs.

Specifically, the combination of prospective PBPM payments and substantial, financially-gated upside-only performance-based payments helps address both the challenges of aligning incentives with clinical value for patients and the overall undervaluation of primary care, albeit with the additional support of CMMI resources. These features may be compelling for more risk-averse or resource-constrained practices. While we will be interested in ongoing MCP evaluation and data, SGIM believes that the MCP model could serve as a template for future primary care value-based care initiatives.

Moreover, to improve participation in APMs, we recommend active engagement of multidisciplinary groups of frontline clinicians, including physicians, nurses, physician-assistants, therapists, and other providers in the process of developing models of care and performance metrics. Additionally, we recommend active work to identify the barriers to participation in APMs from safety net settings and historical non-participants. Adequate support must be provided to overcome these participation barriers, including but not limited to, up-front infrastructure funding, incentives to recruit and retain staff, delayed and/or reduced downside risk, accounting for medical and social complexity of population, longer model run-time, and reduced reporting and administrative burden. Moreover, payments must be adjusted to account for social determinants of health (SDOH). This will simultaneously demonstrate the necessary focus on making care available to everyone, end the historical underpayments and over penalization of safety net systems in value-based programs, and support historical non-participants in making the voluntary transition to value-based models.

Reducing Physician Reporting Burden Related to MIPS

SGIM has concerns about the burdensome nature of physician reporting requirements associated with the Merit-based Incentive Payment System (MIPS). The current landscape of quality measures, which may not significantly affect clinical care and health outcomes, and high reporting burden continues to impede progress toward value-based care. Small, independent primary care practices have less time for patient care, due to involvement in administrative tasks and reporting requirements. Safety net systems, in particular, struggle to meet reporting requirements. SGIM believes that fewer, more aligned measures, and a lower initial emphasis on bonuses and penalties based on quality performance will allow movement toward prospective payments. A greater emphasis on performance-based modification to payments can be implemented over time, once health systems are accustomed to prospective, capitated payments.

Supporting Chronic Care in the Primary Care Setting

SGIM appreciates that the Committee is working to identify methods to appropriately compensate primary care while also reducing administrative burden. Specifically, the Committee is exploring a hybrid payment model that would allow for a PBPM payment, provided in advance to the clinician. The Society asserts that under this model there must be clarification as to who may be eligible to use a hybrid payment model for primary care under the MPFS. Internal medicine physicians and other primary care physicians, including family medicine physicians, pediatricians, and gynecologists, should undoubtedly be considered for participation in this model. However, there

are internal medicine subspecialists, such as hematologists and endocrinologists, who also deliver primary care to a sizable portion of their patient population. Additionally, there are specialists who deliver primary care services to patients with chronic conditions and end-stage diseases because the care is complex and has moved beyond general preventative management. Therefore, this Committee should work with CMS to clarify how primary care is defined for the purposes of hybrid payment.

SGIM believes that the design and implementation of hybrid payment of any kind must: (1) Invest in primary care capacity by supporting personalized, team-based care and paying for services tailored to the needs of the patient and the community; (2) Reduce or simplify the burdensome documentation associated with many service codes, which add to systemic costs and consume clinician time that could be better spent with patients; and (3) Allow for additional, higher payment tiers based on the scope of services, such as greater behavioral health integration and ability to address health-related social needs. It is within this context that we offer the following comments.

Prospective payments have the potential to maintain clinical practice cash flow and capacity-building, particularly for smaller and rural practices, as they provide greater financial stability for practices. To support robust primary care access, capacity, and quality, it is crucial to establish a strong foundation of PBPM payments for primary care services including the care coordination and complex care management inherent in high-quality primary care. For the bulk of primary care services, the core payment model best aligned with and best able to support the actual clinical value of the care delivered is likely to be a risk-adjusted, prospective PBPM payment.

Primary care is intrinsically rooted in the relationship between the patient, physician, and the associated care team. Continuity, accountability, and engagement in this relationship, often based in a patient-centered medical home (PCMH), constitutes the keystone to primary care's clinical value. Thus, a payment model that uses this relationship as the unit of value – PBPM – is most aligned with the actual value delivered by primary care. Notably, this key point is necessary and consistent with the first objective in the National Academies of Sciences, Engineering, and Medicine's *Implementing High-Quality Primary Care* report: "Pay for primary care teams to care for people, not doctors to deliver services."[1] Second, risk adjustment – both medical and social – is crucial to account for the high variance in resources needed to care effectively for primary care patients, to avoid cherry-picking by providers, and to advance health equity. SDOH significantly influences patients' health outcomes and healthcare needs. **Therefore, SDOH, including but not limited to, socioeconomic status, education, environment, employment, social support networks, and access to healthcare, must be considered in any risk adjustment calculation for primary care payment.**

Additionally, SGIM believes it is crucial that physician payment models incentivize the integration of behavioral health services into primary care, including services for mental health care planning and management services. Uptake has been very low for the behavioral health integration (BHI) codes, and we believe that a tiered payment system where there are incentives to provide BHI

[1] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

services, linked to higher reimbursement rates for higher levels of care integration, would encourage more physicians to adopt these services and enhance overall patient care. A Massachusetts model, for example, uses tiered reimbursements to incentivize primary care practices to integrate behavioral health services. A tiered approach, such as this one that gives providers higher reimbursement for meeting specific benchmarks at each tier, would effectively promote BHI in primary care. SGIM, however, would like to clarify that it is essential to ensure that such a model does not impose an excessive amount of documentation burden on providers, as this would take time and resources away from patient care.

Moreover, SGIM is pleased to see that the Committee is interested in alleviating some of the financial burden associated with additional and new primary care codes, such as TCM and chronic care management (CCM) codes, through targeted, reduced cost-sharing to improve care coordination and decrease patient financial burden. We recognize that members of this Committee believe maintaining some level of cost-sharing by beneficiaries is important. **As you consider Medicare payment reform legislation, we urge you to consider removing financial barriers faced by patients accessing comprehensive, whole-person primary care necessary to manage their chronic conditions.** As a starting point, we recommend that you consider removing cost-sharing for BHI and chronic care management services. This policy change alone would improve access, lower patients' costs for these services, and improve health outcomes. Patients with chronic conditions often require frequent and ongoing management; therefore, removing cost-sharing will allow for better management of chronic conditions through regular follow-up visits and enhanced care coordination. Similarly, by making BHI services more accessible, patients are more likely to receive comprehensive care, leading to better care management and health outcomes.

Supporting Chronic Care Benefits in FFS

SGIM applauds the Committee's efforts to address SDOH to improve the health of seniors. However, we strongly believe that the best avenues for addressing social determinants lie further upstream than Medicare policy. Broader anti-poverty policies and larger scale investment in social services, including investment in housing, are critical to the success of any payment system. SGIM recognizes that there is real potential for harm in over-medicalizing SDOH, and that increasing funding to upstream social services is the optimal path, even if it means redirecting funds away from health care.[2]

SGIM supports efforts to ensure that supplemental benefits are covered for patients with chronic conditions. Regarding food insecurity, the Supplemental Nutrition Assistance Program (SNAP) has been demonstrated to improve health outcomes and reduce costs and should be expanded.[3,4,5] However, acknowledging that there may not be realistic options to increase support for upstream

[2] https://rdcu.be/dy9ve
[3] Carlson S, Llobrera J. SNAP Is Linked With Improved Health Outcomes and Lower Health Care Costs. Center on Budget and Policy Priorities, Washinton, DC; December 14, 2022.
[4] Keith-Jennings B, Llobrera J, Dean S. Links of the Supplemental Nutrition Assistance Program With Food Insecurity, Poverty, and Health: Evidence and Potential. Am J Public Health. 2019;109(12):1636-1640. PMC683678742.
[5] Berkowitz SA, Seligman HK, Rigdon J, Meigs JB, Basu S. Supplemental Nutrition Assistance Program (SNAP) Participation and Health Care Expenditures Among Low-Income Adults. JAMA Intern Med. 2017;177(11):1642-1649. PMC5710268

social sector programs at this juncture, SGIM supports Medicare covering benefits such as medical tailored meal (MTM) programs, for which studies have shown reduced readmissions and health care costs.[6,7] SGIM also supports coverage of transportation, given the extensive body of literature describing the detriments imposed on beneficiaries' access to care when there is a transportation barrier. Additionally, at-home services, including grants for small structural home improvements, have been shown to be beneficial to patients.[8,9]

Ensuring the Integrity of the PFS

SGIM has long maintained that E/M services, the primary services billed by our members, must be revisited to improve their accuracy and reliability. Since hybrid and other APMs use the existing MPFS as a foundation, improvements to E/M services are critical even as the Committee explores alternatives to fee-for-service payment for primary care. Over three decades ago, 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 by empiric research. CMS has taken steps in recent years to revisit the E/M services and codes billed by primary care physicians. The agency created new services, like the TCM and CCM codes and revised and revalued E/M services. However, the underlying problems with these services remain as the E/M codes have not fundamentally changed and still do not represent the full range of work delivered to Medicare beneficiaries, particularly those with multiple chronic conditions.

Therefore, the Committee must improve reimbursement for E/M services that are central to the comprehensive care of patients. 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. **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 Senators Sheldon Whitehouse (D-RI) and Bill Cassidy's (R-LA) *Pay PCPs Act*.** 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 APMs 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

[6] https://pubmed.ncbi.nlm.nih.gov/35972131/
[7] https://pubmed.ncbi.nlm.nih.gov/31009050/
[8] https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.17383
[9] https://rdcu.be/dy9ve

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 for application 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 APMs expand, the importance of proper valuation of E/M services and the critical role of a TAC will remain. APMs 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.

Thank you for the opportunity to provide these comments. SGIM is committed to working with you to ensure that the Medicare program is best structured to benefit patients for generations to come. Should you have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

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