

July 15, 2024

The Honorable Sheldon Whitehouse
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
United States Senate
Washington, DC 20510

Dear Senators Whitehouse and Cassidy,

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to respond to this request for information on the *Pay PCPs Act*. 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.

We are deeply appreciative of your efforts to explore policies to bolster primary care. As you recognize, the shortage situation is dire with many Americans without regular access to primary care. We are pleased to provide the following comments on the three portions of the legislation: hybrid payments for primary care providers, cost-sharing adjustments for primary care services, and the technical advisory committee (TAC) to more accurately determine Medicare Physician Fee Schedule (MPFS) rates.

Hybrid Payment for Primary Care Providers

General Comments

SGIM applauds you for considering how to meaningfully support primary care and ensure Medicare beneficiaries have access to comprehensive primary care services. As a member of the Primary Care Collaborative (PCC), we agree that today's Medicare payment policy undermines primary care access and that hybrid payments should support the delivery of team-based care to better meet the needs of patients while reimbursing general internal medicine and other primary care physicians more appropriately for their work. A hybrid payment system must be based on primary care services that are properly defined and valued to be successful. Despite recent efforts by the Centers for Medicare & Medicaid Services (CMS), current evaluation and management (E/M) and other codes designed to capture the physician work required to deliver high-quality primary care still fail to do so. **Therefore, we recommend that the work of the technical advisory committee (TAC) as outlined in this legislation be done expeditiously to inform hybrid payments. Medicare beneficiaries and general internal medicine and other primary care physicians cannot afford to wait for a policy solution to support comprehensive primary care.** By expediting the work of the TAC, per-member per-month (PMPM) payments included in a hybrid payment can be based on inputs that recognize the value of and work required to deliver comprehensive primary care.

As the request for information recognizes, there is a growing shortage of primary care physicians. According to the Primary Care Collaborative's recent report, in 2019, there were 228,936 primary care physicians, including 91,037 family physicians, 78,984 general internal medicine physicians, and 48,842 general pediatricians.¹ Workforce projections from the Association of American Medical Colleges (AAMC) suggest a shortage of primary care physicians of up to 40,400 by 2036, a number that would be higher if it weren't for recent

¹ <https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook2021.pdf>

Congressional investments in Medicare-funded GME.² Additionally, projections from the Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis project a shortage of 68,020 primary care physicians, including a shortage of 30,080 general internal medicine physicians, by 2036.³ The time is now to improve reimbursement and reduce administrative burden to better support primary care physicians and the care teams required to deliver comprehensive primary care.

For hybrid payments to support the reversal of these disturbing workforce trends, 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.

Prospective payments have the potential to maintain clinical practice cash flow and capacity-building, particularly for smaller and rural practices, as this payment approach provides greater financial stability for practices. To support robust primary care access, capacity, and quality, it is crucial to establish a strong foundation of PMPM 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 PMPM payment based on MPFS services that are accurately valued.

Additionally, SGIM recommends that a hybrid payment include robust patient protections. Any Medicare beneficiary whose care is included in this payment arrangement should be made aware of the services included in the PMPM payment, and the physician receiving the PMPM payment should be held accountable for delivering those services. SGIM recognizes that not all beneficiaries whose care falls under a hybrid payment will require the same level of care—those with more complex needs will be subsidized by those with less complex needs. **However, there should be a baseline of services provided to beneficiaries regardless of their clinical complexity, which is clearly communicated to beneficiaries.** For example, beneficiaries should understand what emergency and after-hours services are available; have their prescriptions renewed within two business days of request and their non-urgent questions answered within two to three business days and urgent questions answered on the day they were submitted or the next business day; and have access to asynchronous and synchronous electronic communication and care management.

Furthermore, the legislation should be designed in consultation with HHS and CMS to ensure that guardrails are designed to ensure that participating physicians do not restrict access to the services determined to be included in the PMPM or any other clinically appropriate services. A PMPM is like a bundled payment, and there have been numerous instances where physicians do not deliver all the services included in the bundle. The 10- and 90-day globals are prime examples where not all the included E/M services are delivered to the patient following the procedure.

Identification of Primary Care Clinicians

² <https://www.aamc.org/media/75236/download?attachment>

³ <https://tableau.hrsa.gov/t/BHW/views/WorkforceProjections/SupplyDemandTrend>

Based on the text and discussions with your staff, we understand that physicians who serve as a beneficiary's usual source of care would be eligible for this model. SGIM recognizes that this would include internal medicine and family medicine physicians, gynecologists, and potentially certain internal medicine subspecialists, like endocrinologists and infectious disease specialists, who deliver primary care to a sizable portion of their patient population. **While we applaud you for recognizing there are certain subspecialists who face the same reimbursement challenges as primary care physicians, SGIM urges caution on this topic. More study is needed before implementing a model in internal medicine subspecialties as we are not aware of health services research in this area.**

Determining the "Actuarially Equivalent" Fee-for-Service Amount for the Purpose of Hybrid Payment

As discussed above, SGIM strongly believes that an appropriate PMPM amount cannot be determined using existing MPFS services because of the longstanding undervaluation of E/M and other cognitive work. We wish to reiterate our concern that it is impossible to determine the "actuarially equivalent" amount for a hybrid payment system when the existing MPFS inputs are flawed. **Therefore, we recommend that original empiric research that includes direct observation of representative primary care practices and access to electronic medical record data be used to determine the actuarially equivalent amount for a PMPM in a hybrid payment system.** SGIM has been a longstanding supporter of having an entity, like the TAC authorized in this legislation, take an evidence-based approach to valuing cognitive work and believes that it has an important role to play to developing a hybrid payment system that meets the needs of physicians and beneficiaries.

Services Included in Hybrid Payments

The legislation allows the Secretary of HHS to include care management services, communications such as emails, phone calls, and patient portals with patients and their caregivers, behavioral health integration services, and office-based E/M services for new and established patients, regardless of modality. As proposed, the PMPM payment will cover both face-to-face and non-face-to-face care delivered to patients. **SGIM supports structuring the payment in this manner and stresses that the PMPM payment should cover all the services and work not already covered by the post-service E/M time. Also, we recommend that the payment be large enough to cover the full range of office visit E/M services and the care management and follow-up work that is not recognized by the MPFS.**

Additionally, SGIM believes it is crucial that a hybrid payment system incentivizes 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 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. An 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. Most importantly, the PMPM must be robust enough to support this work as there may be additional staffing costs required to offer BHI services that practices do not currently incur.**

Cost-Sharing Adjustments for Certain Primary Care Services

SGIM is pleased that the *Pay PCPs Act* contemplates reducing co-insurance for beneficiaries who voluntarily designate a primary provider who is their usual source of care by up to 50 percent. We believe that reducing coinsurance by half will be attractive to beneficiaries to make the commitment required to receive care under this hybrid arrangement; a greater reduction in coinsurance would be even more attractive. When beneficiaries stop worrying about the out-of-pocket costs associated with consulting with their primary care physician, they will not hesitate to contact their physician when their health problems are more manageable. SGIM believes that this policy will help incentivize beneficiaries to obtain comprehensive primary care, which is demonstrated to improve health outcomes and reduce Medicare costs.

TAC to Help CMS More Accurately Determine MPFS Rates

SGIM has long maintained that E/M services must be revisited to improve their accuracy and reliability. Since hybrid payments will use the existing MPFS as a foundation, improvements to E/M services are critical to supporting the delivery of comprehensive primary care. Over three decades ago, the principal architect of the resource-based relative value scale, 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 created new services, like the transitional care management and chronic care management 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.

We recognize that other organizations, including the PCC, have not endorsed the TAC. However, SGIM believes that correcting the longstanding deficiencies in the MPFS is required to reverse the disturbing trends in primary care and support the success of innovative payment approaches, like hybrid payments. Therefore, SGIM is pleased that the *Pay PCPs Act* contemplates how to improve reimbursement for E/M services that are central to the comprehensive care of patients by authorizing a TAC and ensuring its membership reflects a diversity of experiences in provider payment and technical expertise in Medicare payment policies. Better reimbursement for these E/M services would support the comprehensive care that primary care physicians and many specialists deliver to patients with complex conditions such as diabetes mellitus, congestive heart failure, and kidney failure. **SGIM believes that establishing a TAC to define and value E/M and other non-procedural work is critical to appropriately reimburse primary care services and supporting the delivery of high-quality comprehensive care. Revisiting the E/M code families should be the first charge of the new entity.** We believe 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 for hybrid and other innovative payments. 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 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. We hope that once the TAC completes its assessment of E/M and other cognitive services that a process would be established to regularly review these services. Even as hybrid payment and other APMs expand, proper valuation of these services is critical to ensure that the models' inputs are accurate. Otherwise, new payment models will perpetuate the MPFS' reimbursement inequities.

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,