September 9, 2024

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 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1807-P)

Dear Administrator Brooks-LaSure:

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) Proposed Rule. 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. 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 2025
- Payment for Medicare Telehealth Services
- Valuation of Specific Codes
- Request for Information for Services Addressing Health-Related Social Needs
- Evaluation and Management Visits

**Conversion Factor for 2025**

The conversion factor for 2025 is set to decrease by approximately 2.80% from $33.2875 to $32.3562. We recognize that this decrease is primarily the result of a statutory 0% update scheduled for the MPFS, and the expiration of funding Congress added to the MPFS for 2024. The continued cuts to the conversion factor have had detrimental impacts on general internal medicine physicians and Medicare beneficiaries' access to their services. 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 exacerbated 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 continue working with Congress to address this issue and recommend that the agency continue to do so as well.**

**Payment for Medicare Telehealth Services**
*Audio-only Communication Technology to Meet the Definition of "Telecommunications Systems"*
CMS proposes to revise the definition of an interactive telecommunications system to also include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician is technically capable of using an audio/video system, but the patient is not capable of, or does not consent to, the use of video technology. The agency notes that practitioners should continue to use their clinical judgment to decide if audio-only technology is sufficient to provide a telehealth service. However, the agency recognizes that lack of access to broadband may make video calls impractical or that patients may prefer to engage with their practitioner in their homes using audio-only technology.

SGIM thanks the agency for this proposal as it will undoubtedly expand access to virtual health care services. 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 visits, SGIM members have successfully worked with individuals to manage various chronic diseases, including but not limited to diabetes and hypertension. **We urge the agency to finalize this policy as proposed to protect access to care for some of the most vulnerable Medicare beneficiaries.**

*Distant Site Requirements*
CMS proposes to continue to allow a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. SGIM supports the agency's proposal to allow distant site practitioners to use their enrolled practice location instead of their home address when providing telehealth services through CY 2025. This policy strikes the correct balance between maintaining practitioner privacy and ensuring continued access to telehealth services. **Therefore, we urge the agency to finalize this policy as proposed.**

*Direct Supervision via Use of Two-way Audio/Video Communications Technology*
CMS 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, 2025. The agency proposes to permanently adopt the definition of direct supervision, permitting virtual presence for services that are considered lower risk and require "incident to" supervision.

SGIM continues to support CMS's proposal to continue allowing virtual direct supervision through real-time audio and visual telecommunication. This approach enhances access to care, particularly for lower-risk services, by maintaining the flexibility needed to deliver timely and effective care while ensuring that patient safety and care quality are not compromised. We are pleased that the agency proposes to continue to permit direct virtual supervision, the presence and "immediate availability" of the supervising practitioner, through real-time audio and visual interactive

telecommunications through December 31, 2025. **While we encourage the agency to finalize this policy, as proposed, we urge the agency to extend this flexibility on a permanent basis to ensure that physicians and their patients have access to these services.** Providing this increased certainty would encourage health systems, especially smaller ones, to invest in the infrastructure and changes needed to provide telehealth services as efficiently as possible for years to come.

*Teaching Physician Billing for Services Involving Residents with Virtual Presence*
CMS proposes to continue the current policy through December 31, 2025, that allows teaching physicians to have a virtual presence when billing for services involving residents in teaching settings only when the service is furnished virtually (i.e., the patient, resident and teaching physician are all in separate locations).

This flexibility is another important tool to expand access to care, particularly in shortage specialties like general internal medicine. Remote or 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 all 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. **Therefore, we recommend that CMS finalize this policy as proposed to continue allowing teaching physicians to bill for services provided by residents when they are supervising remotely.**

*Request for Information for Teaching Physician Services Furnished under the Primary Care Exception*
SGIM recognizes that CMS has received requests to permanently expand the list of services that can be furnished under the primary care exception (PCE) to include all levels of E/M services and additional preventive services. We appreciate the opportunity to assist the agency in its assessment of whether and how best to expand the array of services included under the PCE in future rulemaking.

First and foremost, while we support expanding PCE services, we recognize that direct supervision is an important part of patient care because it ensures that attending physicians can provide oversight and immediate guidance. In particular, direct supervision is most valuable when the history and physical exam are crucial to diagnosing and managing the patient's chief complaint. Since CMS adopted several changes to office/outpatient E/M billing in 2021, E/M levels are based on the number and complexity of problems addressed and only require a medically appropriate history and physical exam. As a result, E/M levels are no longer a reliable indicator for determining when direct supervision is needed and may not be the best criterion for applying the PCE.

SGIM emphasizes that, in addition to complexity, the severity of the patient's condition should also be a key factor when determining the level of care requiring direct attending supervision. Direct supervision is most critical in cases of serious or life-threatening conditions, which are not limited to level 5 outpatient E/M visits. Additionally, the differences between new and established patient

visits should not be overlooked as direct supervision may often be more important for new patients than established patients.

Consequently, SGIM supports level 4 outpatient E/M visits (CPT codes 99204 and 99214) being included in the list of services that can be furnished under the PCE, but only after competency-based assessments have been incorporated into determining residents' readiness to be supervised under the PCE. Residents who are meeting Accreditation Council for Graduate Medical Education's milestones toward independent practice should be able to conduct level 4 E/M visits with indirect attending supervision.

Additionally, we believe that certain preventive services, including the annual wellness visit, vaccine administration, and other Medicare Part B preventive services, such as tobacco cessation and obesity counseling, should also be included, as residents who have demonstrated competency to perform these services under indirect supervision should be permitted to do so.

Expanding the list of services, including level 4 E/M and preventive services, under the PCE has the potential to improve the quality of residency training in primary care settings, although the impact may vary depending on current practices in each teaching clinic. This, in turn, could foster residents' growth by enabling them to handle more complex visits with less supervision, provided that competency-based assessments are used. This expansion would also provide bandwidth for teaching physicians to supervise additional residents. However, we reiterate that it is essential to recognize that complexity alone is not always the best determinant of supervision needs. The severity of the patient's condition should be considered, even though E/M codes may not always capture this distinction.

Lastly, SGIM believes that the current 6-month benchmark for determining residents' readiness for supervision under the PCE is arbitrary and does not accurately reflect individual progress. Residents may achieve competency either before or after this point in time. We recommend using ambulatory entrustable professional activities (EPAs) as a more precise measure of when residents are ready for supervision under the PCE. This approach should be applied even if the PCE is expanded to include higher-level E/M and preventive services.

**Valuation of Specific Codes**

*Telemedicine Evaluation and Management (E/M) Services (CPT codes 9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088, 9X089, 9X090, and 9X091)*

SGIM recognizes that the CPT Editorial Panel created and the AMA RUC valued 17 new codes for telemedicine E/M services, closely mirroring outpatient visit E/M codes. Noting that these services are already on the Medicare telehealth services list, the agency believes that there is no need to recognize and provide payment for the newly established telemedicine E/M codes.

**SGIM agrees with the agency's proposal not to adopt the new telemedicine E/M codes.** Adopting these additional codes could create confusion for practitioners, especially depending on how they

are integrated into EMR systems. It is more efficient to continue using the existing telehealth codes along with appropriate modifiers and place of services codes that are already familiar to practitioners. In fact, maintaining the current number of codes simplifies administrative processes for them.

**Request for Information for Services Addressing Health-Related Social Needs**
SGIM recognizes that the agency is requesting additional information on ways to improve the new services addressing health-related social needs, address any care gaps that may not be covered by the new codes, and possibly create additional codes within the scope of this policy. Our members have identified a need for clarification on whether certification is required to bill these codes. **Specifically, CMS should clarify whether community health workers (CHWs) and case managers need specific certification to bill for these services**. Additionally, clear guidance on which professionals—CHWs, social workers, nurse case managers—are eligible to bill for these services would help streamline implementation. Additionally, successful implementation requires coordination across multiple departments within health systems, including EMR/IT, Compliance, and Population Health. For example, IT departments must develop documentation workflows, compliance departments need to approve these workflows, and population health teams are responsible for managing and training staff. Ensuring alignment between these departments is crucial for effective implementation of these services. **Therefore, SGIM recommends that CMS explore and evaluate models of care that facilitate such alignment between departments to ensure seamless communication and improve patient outcomes.**

**Evaluation and Management Visits**
*Office/Outpatient (O/O) E/M Visit Complexity Add-on*
In the CY 2024 MPFS final rule, CMS finalized separate payment for the O/O visit complexity add-on code G2211 to reflect "the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M visits that enable them to build longitudinal relationships with all patients…and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time." The final policy prohibited payment for the add-on code when the O/O E/M code is reported with modifier -25. In response to stakeholder concerns, CMS proposes to allow the add-on code to be billed when an O/O E/M code is reported on the same day as an annual wellness visit (AWV), vaccine administration service, or any Medicare Part B preventive service delivered in the office or outpatient setting. SGIM appreciates the agency's willingness to expand the use of G2211. **We urge CMS to finalize this proposal and consider allowing the use of the G2211 with other services that may be billed with modifier -25, including advanced care planning, smoking and tobacco cessation, and preventive medicine counseling services.**

- CPT code 99497: Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

- CPT code 99498: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
- CPT code 99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- CPT code 99407: Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
- HCPCS code G0447: Face-to-face behavioral counseling for obesity, 15 minutes
- CPT code 99401: Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- CPT code 99404: Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

*Advanced Primary Care Management Services (HCPCS codes GPCM1, GPCM2, and GPCM3)*
The agency proposes to adopt coding and payment policies to recognize advanced primary care management (APCM) services (HCPCS codes GPCM1, GPCM2, and GPCM3) for use by practitioners providing these services based on experiences in the CMS Innovation Center's testing of advanced primary care models. **SGIM greatly appreciates the agency's proposal to reimburse a newly defined set of three APCM codes to recognize the resource costs, including maintaining 24/7 access to practitioners and shortened turnaround times in response to portal messages, associated with the delivery of these services.** These new codes would reflect the effectiveness and growing adoption of advanced primary care, ensure beneficiaries receive a broader range of primary care services, and begin to reimburse practices for the higher costs associated with the delivery of comprehensive advanced primary care services.

While SGIM appreciates CMS's commitment to appropriately valuing and reimbursing primary care within the traditional fee-for-service (FFS) Medicare system, we believe there are significant details that still need to be addressed and substantial barriers that must be overcome for this proposal to have a meaningful impact. However, general internal medicine and other primary care physicians cannot afford to wait much longer for Medicare reimbursement to match the comprehensiveness and value of the care they deliver to Medicare beneficiaries. Without real financial policy changes, SGIM does not see how to reverse the workforce shortages facing primary care, which is of particular concern as the number of Medicare beneficiaries continues to grow. **To this end, we strongly recommend that CMS finalize the policy but delay the implementation of these services until CY 2026.** This delay would allow CMS to collaborate closely with stakeholders, including SGIM, to make revisions to the policies during the CY 2026 rulemaking cycle to ensure that the program being implemented truly supports advanced primary care delivery. SGIM is eager to work with you to implement these services in a manner that minimizes burden and promotes widespread adoption.

SGIM has developed the following principals related to hybrid payment and we think they should apply to APCM services: (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.

In the interim, we wish to provide the following comments on the agency's APCM proposals:

Valuation of APCM Services –
SGIM believes the proposed values for the APCM codes are insufficient and do not accurately reflect the resource costs required to deliver these services. Adjustments are needed to ensure the compensation aligns with the actual expenses incurred in providing quality care. **We recommend that CMS conduct an empirical investigation to more accurately measure these costs**. Should the agency delay implementation of these codes, there will be time to incorporate empirical measurement into the valuation of these services.

Attribution –
Accurate patient attribution for these services is crucial, particularly because there are no limits on what type of practitioner can bill these services as long as the codes' criteria are met. Ideally, this should be done prospectively to help practitioners identify patients for these services and guide population health strategies. However, this can be challenging due to potential billing conflicts if patients switch providers or see multiple practitioners. Proper attribution is also essential for quality assessments and determining eligibility for CMS quality payment incentives. While retrospective attribution may be necessary to account for performing these services in a fee-for-service environment and patient care changes, it could hinder effective population health strategies. **SGIM recommends that this be a topic explored further with stakeholders should the implementation of this proposal be delayed.**

APCM Code Levels –
The agency proposes that the APCM codes be stratified into three levels based on certain patient characteristics that are broadly indicative of patient complexity and the consequent resource intensity involved in the delivery of these services in the context of advanced primary care. Level 1 patients would have one or fewer chronic conditions, Level 2 patients two or more chronic conditions, and Level 3 patients would be Qualified Medicare Beneficiary (QMB) with two or more chronic conditions. CMS proposes to use QMB status to identify beneficiaries with social risk factors that generally require greater resources to deliver advanced primary care effectively; these individuals are generally more medically complex and have greater healthcare needs.

SGIM appreciates CMS's efforts to stratify the APCM codes based on patient complexity and resource intensity, recognizing the importance of addressing the needs of patients with varying levels of chronic conditions. However, we believe the current proposed stratification may not fully account for the severity of individual conditions. Some patients with a single, but very serious

condition, may require significantly more resources than patients with multiple chronic conditions that are stable or less severe. By focusing solely on the number of chronic conditions, this stratification could overlook the nuanced differences in resource needs based on condition severity and complexity. **We recommend that CMS further evaluate and refine the stratification scheme to incorporate additional factors such as the severity of individual conditions, social risk factors beyond QMB status, and other indicators of medical complexity.** Doing so would more accurately reflect the resource intensity required for effective advanced primary care delivery.

SGIM appreciates CMS's recognition of the role social risk factors play in health outcomes and healthcare delivery. While dual-eligible status has traditionally been used as a measure of social risk, data has shown that this marker is not sufficiently sensitive to capture all at-risk beneficiaries. As health services research continues to evolve in identifying social risk, no single marker has yet been proven to be appropriately sensitive. **Therefore, SGIM supports employing multiple approaches to capture social risk comprehensively, including models where various indicators—such as QMB status or placement in the highest quintile of an area-based index like the Area Deprivation Index—would qualify a beneficiary in the interim.** CMS Innovation Center models are also exploring alternative indices and methods to capture social risk. Given the historical under-recognition of social risk as a factor in healthcare payments and quality measures, **SGIM supports utilizing the broadest possible criteria to identify and address social risk effectively.**

**Additionally, we recommend that CMS consider an additional code level that captures more complex patients who may not fall into QMB status.** There are many patients with significant clinical complexity and healthcare needs that do not meet QMB criteria but still require intensive resource utilization. Including an additional code level to the APCM code family would help ensure that these patients receive appropriate care and that practitioners are adequately compensated for the higher resource demands associated with their care.

Consent and Copayments –
The QMB program provides Medicare coverage of Part A and Part B premiums and cost sharing to low-income Medicare beneficiaries. While SGIM recognizes that QMBs whose practitioners bill HCPCS code GPCM3 will not be subject to copayments, many vulnerable Medicare beneficiaries receiving services billed under HCPCS codes GPCM1 and GPCM2 will still be subject to copayments. This is counterproductive, as imposing copayments for longitudinal, wraparound care coordination and care management services between billable E/M visits fundamentally contradicts the principles of chronic care management and APCM services.

We recognize that CMS does not have the authority to waive copayments; however, it is crucial to emphasize that the evidence supporting copayments, largely derived from the outdated RAND health insurance experiment, is no longer sufficient. Recent research highlights the significant harm that out-of-pocket costs inflict on vulnerable patients with chronic conditions, particularly those with social risk factors.

Additionally, we recognize that the proposed patient consent requirement is intended to ensure that patients do not incur unexpected expenses for care. SGIM appreciates that practitioners are

not required to obtain consent monthly as that would place an unnecessary administrative burden on both patients and practitioners. **We also recommend that CMS provide additional guidance on the consent process to ensure that both patients and practitioners understand and are in alignment.**

The requirements for consent and copayments could lead to skepticism, distrust, and reduced uptake of these essential services. Practitioners might continue to deliver these services without reimbursement, as they have traditionally done, which would undermine the financial relief this proposal aims to provide. Currently, services like coordination with specialists and follow-up calls to discuss next steps are often provided without charge. Many practitioners might avoid seeking consent or billing for these services to preserve trust and avoid the extra time needed to explain this new policy to every patient. This issue fundamentally threatens to undermine the intent of the proposed policies. It is important to note that the historically low uptake of new codes like the chronic care management (CCM) and transitional care management (TCM) due to similar barriers suggests APCM services could face the same issues.

APCM Service Elements and Practice-Level Capabilities –
CMS proposes that APCM services would include nearly the same scope of service elements and conditions as the CCM and principal care management (PCM) services, including 24/7 access, care continuity, care management and care plan, care coordination, management of care transitions, and enhanced communication. CMS outlines the practice capabilities required to deliver these services in the proposed rule.

SGIM believes the proposed elements and requirements reflect the services consistent with effective APCM care and these standards are consistent with current CMS primary care models and demonstration projects. However, while most practices may be set up to deliver these services, some of these elements may pose challenges for certain primary care practices to meet, such as community-based care coordination if it extends beyond the routinely used home health services, or population-level management due to additional resources and coordination needed. For example, lower income and QMB patients may receive their primary care in settings that currently do not meet these standards, such as low resource safety net providers. This could potentially exacerbate disparities in care and reimbursement for patients at the highest risk. **For these reasons, SGIM appreciates that CMS is proposing that not all elements must be furnished during any given calendar month for which the services is billed.**

**Additionally, while it is understandable that certain requirements must be met for clinics to demonstrate their capacity to bill APCM codes, SGIM is concerned that safety net clinics will continue to face under-reimbursement for the critical care they provide.** Clinics that do not meet the requirements but still deliver substantial care coordination, management, and advanced primary care services to chronically ill beneficiaries with social risk—often with limited resources to expand their capacity—are particularly vulnerable to under-reimbursement. For these reasons, implementing tiered practice capability requirements could address the current "all or nothing" approach, where some practices that invest significant time and resources in chronic care management but fall short of the requirements are ineligible for reimbursement for their currently

uncompensated care. We welcome the opportunity to work with CMS to determine which requirements are required to deliver APCM services.

Billing Requirements –
CMS proposes that APCM services would only be billable once per month by a single practitioner who assumes the care management role for the beneficiary. Additionally, CMS acknowledges that there are care management services, such as the CCM, PCM, and TCM codes, which are likely to be "substantially duplicative" of APCM services, and therefore, they would not be billable during the same time period as APCM. To address instances where an APCM service is billed, but other care management services are also billed and provided by the same practitioner or a different practitioner in the same practice, CMS should adopt a policy that ensures fair reimbursement for the services rendered.

Consider a patient with diabetes who sees both a general internist and an endocrinologist for their care. The endocrinologist may take on a significant portion of the care management services, such as monitoring blood sugar levels and adjusting medications, while the general internist might focus on the patient's overall health and preventative care. This is a key example of how resource allocation can be complicated between providers when specialists are providing care management of chronic conditions.

Therefore, given that new coding practices take time to integrate accurately into practice, if an APCM code is billed alongside CCM, PCM, and TCM services, CMS should reimburse the higher amount of the two options. Specifically, CMS should pay either the APCM code or the total of the cumulative individual CCM, TCM, PCM codes billed within that month – whichever amount is greater. This will help ensure that practitioners are adequately compensated for the comprehensive care they deliver, regardless of the billing method used.

Thank you again for the opportunity to provide comments on this proposed rule. SGIM looks forward to working with you to protect patients' access to high quality primary care. Should you have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

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