January 13, 2025

President-Elect Donald J. Trump
Vice President-Elect James D. Vance
c/o Linda McMahon and Howard Lutnick, Co-Chairs
President-elect Donald J. Trump's Transition Team

Sent via email to johnbrooks83@gmail.com

Dear President-Elect Trump and Vice President-Elect Vance,

On behalf of the Society of General Internal Medicine (SGIM), we want to extend our congratulations on the 2024 election and look forward to collaborating with you to address the health care challenges facing Americans. Specifically, we look forward to working with you to strengthen primary care and ensure all individuals have access to comprehensive, high-quality primary care services. 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 delivering high-quality clinical care for adults of all ages, especially those with multiple chronic diseases who would benefit from having a physician to coordinate a comprehensive approach to their care.

Thank you for considering the following policy recommendations, which focus on three priority areas: clinical practice, educating the next generation of physicians, and medical research. We believe these will help achieve better health for all Americans.

Support the Delivery of Comprehensive Primary Care

SGIM appreciates the incoming Trump administration's interest in combatting chronic disease in the United States. We firmly believe that primary care is the foundation of a strong health care system. However, despite the robust evidence that primary care improves health outcomes, there are insufficient incentives and infrastructure to allow primary care to deliver on its promise. The shortages of general internal medicine and other primary care physicians are well documented[1], and the inadequate reimbursement for primary care services has only perpetuated this shortage. Without meaningful change, more Americans—regardless of where they live—will lose access to comprehensive primary care. **SGIM hopes that this is an area where we can partner with your incoming administration.**

As general internal medicine physicians, SGIM members cultivate trusting, long-term relationships with their patients—many of whom are Medicare beneficiaries. These relationships enable physicians to effectively manage chronic conditions, such as congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, hypertension and diabetes while addressing the complex interplay between the conditions and the therapies to treat them. By delivering the most effective screening tests and preventive care, general internal medicine physicians prevent the development of more acute and costly health problems. This comprehensive approach to

[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf

primary care is vital in improving the health and well-being of vulnerable individuals, especially those over the age of 65 who often have multiple chronic diseases. To save primary care and bolster chronic care delivery, Medicare must do more to support a primary care system that keeps people healthy.

Support for reforms to primary care and chronic care coordination are hindered by longstanding problems with the Medicare Physician Fee Schedule (MPFS) – the payment system that determines reimbursement for services provided by physicians to Medicare beneficiaries. As is well documented, Medicare physician reimbursement has stagnated over the past two decades without increases or adjustments for inflation, or to account for increased costs of delivering care, an oversight that is in stark contrast to other Medicare fee schedules. The Hospital Outpatient Prospective Payment System and Hospital Inpatient Prospective Payment System, and the End-Stage Renal Disease Prospective Payment System among others have all received inflationary increases over the last two decades. According to an American Medical Association (AMA) analysis of Medicare Trustees data, the average inflation-adjusted Medicare payment per physician service has declined by 29% from 2001–2024. This decline has occurred despite rising health care expenses, creating a significant gap between increasing costs and decreasing physician payments.

The MPFS' budget neutrality requirement exacerbates this issue, as positive updates for certain services or the addition of new codes inevitably result in payment reductions for others. This structural limitation prevents Congress and the Centers for Medicare & Medicaid Services (CMS) from implementing reforms necessary to support high-quality, coordinated primary and chronic care. **SGIM strongly urges your administration to collaborate with Congress to enact comprehensive reforms that safeguard primary care while placing the MPFS on a more sustainable trajectory.** For example, Congress should raise the budget neutrality threshold above $20 million to $53 million to allow for more flexibility in adjusting physician payments and provide for an increase every five years equal to the cumulative increase in MEI. These policies are straightforward and will ensure that physician payments keep pace with inflation and the cost of delivering care.

Implementing Hybrid Payment Models

SGIM believes that hybrid payment models that allow for a per-beneficiary, per-month (PBPM) payment can serve as a method to appropriately compensate for primary care services and improve the value of the care being delivered to Americans while also reducing administrative burden. 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 PBPM 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. This stability is especially critical given that many rural practices are at risk of closing, a trend that has already left large parts of the country where patients must travel significant distances to access a primary care physician. By offering consistent and predictable funding, PBPM payments can help prevent further closures, ensuring access to essential primary care services for rural and underserved populations. **Therefore, SGIM encourages your administration, through CMS, to establish a strong foundation of PBPM payments for primary care services to support the care coordination and complex care management inherent in the delivery of both chronic care management services and high-quality primary care.**

Ensuring the Integrity of the MPFS

SGIM has long maintained that evaluation and management (E/M) services, the primary services billed by our members for office visits, must be redefined and revalued to improve their accuracy and reliability even as we prepare to move to a hybrid payment system and value-based care. Over three decades ago, the principal architect of the resource-based relative value scale (RBRVS), Dr. William Hsiao clearly stated that the development of the E/M portion of the MPFS was not adequately supported by empiric research. Your first administration made important changes to address the longstanding criticism that the documentation requirements for E/M services were overly burdensome and increased payment for office and outpatient E/M services. This policy represented the first significant changes to these services in almost two decades. 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.

CMS must improve reimbursement for E/M services that are central to the delivery of comprehensive and value-based care to Medicare beneficiaries and all Americans. **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.** The *Pay PCPs Act of* 2024 (S.4338), introduced by Senators Bill Cassidy (R-LA) and Sheldon Whitehouse (D-RI), includes a provision to authorize a TAC. This has been a longstanding priority of our professional society, and we believe that a TAC will help to ensure that the MPFS is accurate, reliable, and publicly accountable. Additionally, proper valuation of these services will ensure that the building blocks used to develop value-based payment systems do not perpetuate the deficiencies of the current fee-for-service system.

A TAC could assess the existing processes for service code development and valuation and propose solutions that are sustainable and supported by valid data. Specifically, the TAC can determine how to base payments on the intensity of cognitive work of physicians by establishing a reliable process for defining services and assigning values. The existing mechanisms for valuing cognitive work are not based on data and have helped perpetuate a system that has not prioritized primary care while the volume and value of technical and procedural services have grown.

As the population ages, Medicare must lead the way in supporting primary care and other cognitive services designed to keep people healthy. We believe that a regular, independent assessment of available data and recommendations based on that data will stabilize what has evolved to become

an irregular valuation process for office visits. This irregular valuation process has been a major contributor to the declining primary care workforce. Appropriate valuation of primary care will remain critical to ensure resources are appropriately distributed to enable high quality, comprehensive, patient-centered care. **Therefore, we urge your incoming administration to support the establishment of a TAC either through legislation or administratively.**

Support a Robust Primary Care Workforce

SGIM is deeply concerned about the country's severe primary care workforce shortages because the healthcare system will never be able to manage the nation's chronic conditions and improve their health without a strong primary care foundation. In nearly all areas of the country, people with serious medical conditions, who do not already have a primary care physician, cannot get an appointment with a general internal medicine physician who has special expertise in meeting the comprehensive care needs of adults. These shortages are most severe in rural and underserved communities.

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.[2] The National Center for Health Workforce Analysis projects a shortage of 87,150 primary care physicians in 2037, including a shortage of 28,890 general internal medicine physicians.[3] SGIM is concerned about this data and recent research showing that half as many medical residents are choosing a career in general internal medicine compared to 10 years ago.[4] This decline is magnified by a large portion of the primary care physician workforce nearing retirement age[5] and the anticipated health care demands as the country's population ages. Additionally, retirement rates due to burnout among primary care physicians are increasing and pose significant concerns. Increasing administrative burden—the reduction of which was a priority of your first administration—coupled with insufficient reimbursement has pushed some physicians into early retirement.[6] SGIM recognizes the supportive role advanced practice providers (APPs) play in the healthcare system and their ability to expand access to care; however, APPs are not a substitute for and cannot fully replace the skills provided by primary care physicians, particularly in caring for patients with multiple and complex chronic conditions. **This predicted shortage highlights the urgent need for increased federal investment to train and prepare new primary care physicians.**

The primary care workforce must adapt to deliver quality care, yet challenges like compensation disparities and burnout hinder recruitment and retention efforts. **To address the ongoing crisis in primary care, the Trump administration must prioritize policies that support solutions for strengthening the primary care workforce.** This should include a comprehensive review of current and projected healthcare workforce needs, an evaluation of existing federal training programs, an

[2] https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook2021.pdf
[3] https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand
[4] Paralkar N, LaVine N, Ryan S, et al. Career Plans of Internal Medicine Residents From 2019 to 2021. JAMA Intern Med. 2023;183(10):1166–1167. doi:10.1001/jamainternmed.2023.2873
[5] https://www.aamc.org/data-reports/workforce/data/active-physicians-age-specialty-2021
[6] https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the_healthcare-staffing-shortage.pdf

analysis of effective financing mechanisms for healthcare education and careers, and the development of a strategic plan to eliminate barriers to primary care recruitment and retention. By supporting these efforts, the administration can help to strengthen the role of primary care as the cornerstone of high-quality healthcare in the United States.

Medicare Graduate Medical Education (GME)
The Medicare GME program 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 approximately 80 percent or $12 billion was financed by Medicare.[7] **The GME program must be redesigned to achieve long-term stability in the financing of medical training and align the supply of physicians in various specialties with national needs, including addressing shortages in primary care, to improve access to and delivery of health care services.** This includes addressing the critical shortage of primary care physicians and ensuring that funding supports specialties with the greatest documented need, such as general internal medicine and other primary care specialties.

SGIM emphasizes that federal investment in additional Medicare-funded GME slots for primary care is necessary to address the critical shortage of primary care physicians. Any increase in overall GME slots must include dedicated slots for primary care specialties with well-documented shortages as increasing slots without specific policy will perpetuate the procedure-oriented specialty system we have today. Additionally, SGIM supports improved GME transparency and data collection to ensure that GME dollars are spent transparently and exclusively for resident training and related costs. This will enhance transparency and accountability in the Medicare GME program for years to come. **SGIM looks forward to working with you to ensure ongoing and sufficient federal support for Medicare GME to meet the nation's growing demands for primary care services, particularly in rural and underserved communities.**

Invest in Health Services Research
To support a high performing healthcare system that improves Americans' health, policymakers and practitioners must understand what processes and interventions directly improve care. This knowledge will be critical for your administration to make progress reversing the high rates of chronic disease. Health services research has helped to support improvements in the quality, safety, effectiveness, and efficiency of health care. For example, health services research has established practices for improving patient safety, including, but not limited to, reducing catheter-related bloodstream infections. Primary care research, a form of health services research, is conducted by members of the care team, with their patients and the communities they serve to translate science into the practice of medicine. Such research informs policies to improve health outcomes and the value of the care delivered and to identify strategies to reduce health care costs: two goals SGIM shares with your incoming administration.

The Agency for Healthcare Research and Quality (AHRQ) is the only federal research agency with the sole mission of producing evidence to make health care safer; of higher quality; more accessible, and affordable; and to ensure that the evidence is understood and used. AHRQ's

[7] https://www.cbo.gov/budget-options/54738

National Center for Excellence in Primary Care Research has made significant investments in research to support primary care transformation to meet the country's care needs. For example, the EvidenceNOW initiative uses a model of external support to help primary care practices in a range of states across the country implement the latest evidence into practice and improve their capacity for quality improvement.[8] Specifically, these investments have focused on heart health, behavioral health and substance use disorders, care coordination, health information technology and digital health.

SGIM recognizes the indispensable role that AHRQ plays in enhancing the effectiveness, safety, and efficiency of health care delivery in the United States. The research and programs funded by AHRQ contribute invaluable insights, innovative practices, and solutions that ultimately improve patient outcomes, reduce health care costs, and promote the overall wellbeing of our nation. **SGIM urges your administration to continue to support AHRQ's vital work in supporting groundbreaking research initiatives, disseminating best practices, and facilitating collaboration among researchers, health providers, and policymakers.**

Thank you for the opportunity to share our expertise on these important issues. We welcome the opportunity to meet with you and your administration to discuss these issues further. Please direct any questions and correspondence to Erika Miller at emiller@dc-crd.com.

Sincerely,

Jada Bussey-Jones, MD, FACP
President, Society of General Internal Medicine

[8] https://www.ahrq.gov/evidencenow/projects/index.html#:~:text=The%20EvidenceNOW%20initiative%2C%20one%20of,their%20capacity%20for%20quality%20improvement

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