June 30, 2025

Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Kennedy,

The Society of General Internal Medicine (SGIM) shares your commitment as Secretary of the Department of Health and Human Services (HHS) to improving the health of Americans, particularly by reducing the burden of chronic diseases. We believe that access to comprehensive, high-quality primary care is the foundation of a strong healthcare system and look forward to working with you to ensure HHS supports access to primary care services for all Americans.

The National Academy of Sciences, Engineering, and Medicine defines high-quality primary care as the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.[1] This definition emphasizes the importance of a comprehensive, patient-centered approach that considers not only physical health but also mental, emotional, and social well-being.

SGIM is a member-based medical association of more than 3,000 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.

Support the Delivery of Comprehensive Primary Care

Despite the robust evidence that primary care improves health outcomes, there are insufficient incentives and infrastructure in the country's healthcare system to allow primary care to deliver on its promise. The shortages of general internal medicine and other primary care physicians are well documented[2], 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, exacerbating the country's chronic disease epidemic.

As general internal medicine physicians, SGIM members cultivate trusting, long-term relationships with their patients—many of whom are Medicare beneficiaries. These relationships

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

1500 King Street • Suite 303 • Alexandria • VA 22314
Tel: 202.887.5150 • 800.822.3060
Web: http://www.sgim.org

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 these conditions and the therapies and lifestyle interventions to treat them. By delivering the most effective preventive care, general internal medicine physicians prevent the development of more serious and costly health problems. This comprehensive approach to primary care is vital in improving Americans' health and well-being, especially those over the age of 65 who often have multiple chronic diseases.

Ensuring access to primary care and chronic care coordination has been hindered by longstanding problems with the Medicare Physician Fee Schedule (MPFS), the payment system that determines reimbursement for services delivered by physicians to Medicare beneficiaries. As is well documented, Medicare physician reimbursement has stagnated over the past two decades failing to keep up with inflation, or to account for increased costs of delivering care. This stands in stark contrast to other Medicare fee schedules. The Hospital Outpatient Prospective Payment System, Hospital Inpatient Prospective Payment System, the End-Stage Renal Disease Prospective Payment System, and others all incorporate regular inflationary increases. 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 effects of this reimbursement stagnation have been particularly challenging for general internal medicine and other primary care disciplines as medical students increasingly choose more lucrative specialties with better perceived quality of life. **Therefore, we urge you to use the administration's authority and work with Congress when necessary to enact common sense reforms to support primary care, including improved reimbursement for cognitive and preventive services.**

Implement Hybrid Payment Models and Reduce Administrative Burden

SGIM believes that hybrid payment models that allow for a per-beneficiary, per-month (PBPM) payment can 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 models 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.

SGIM recognizes that the Center for Medicare and Medicaid Innovation (CMMI) is refining its strategic direction to build healthier lives through evidence-based prevention, patient empowerment, and greater choice and competition.[3] As part of this realignment, CMS has terminated two primary care models, Primary Care First (PCF) and Making Care Primary (MCP), shifting its focus on different approaches that are "consistent with CMMI's statutory

[3] https://www.cms.gov/priorities/innovation/about/strategic-direction

mandate and produce savings."[4] Despite the termination of these models, SGIM is pleased that CMMI's updated strategic vision includes the use of advanced shared savings and prospective payments to support the participation of independent practices in future models.[5] **The Society encourages you to establish a system of PBPM payments to support the care coordination and complex care management inherent in the delivery of both chronic care management services and high-quality primary care in the Medicare program.**

Ensuring the Integrity of the MPFS

SGIM has long maintained that evaluation and management (E/M) services, the services billed by our members for office visits, must be redefined and revalued to improve their accuracy and reliability to support an effective system of hybrid payments and value-based care; this will prevent the perpetuation of the current deficiencies of the fee-for-service system in these new models.

In 2019, the Trump 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.

When the MPFS was established, Congress did not specify a process for the Centers for Medicare & Medicaid Services (CMS) to ensure that service code valuations were updated regularly to ensure their accuracy and reliability. At the time, the AMA convened the Relative Value Scale Update Committee (RUC), which is primarily composed of proceduralists, to do this work, and CMS came to depend almost exclusively on its recommendations for service valuations. Unfortunately, the annual MPFS continues to undervalue E/M and other cognitive care that has the potential to reduce Americans' reliance on procedures and sick care. This disparity between the valuation of cognitive and procedural care has driven the challenges Americans face receiving high-quality primary care and other preventive services. SGIM agrees with you that the AMA has too much influence over physician compensation. **Therefore, we recommend that CMS reduce its excessive reliance on the RUC's recommendations, particularly for cognitive services, by establishing a more transparent approach to valuing physician services.**

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

[4] https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-and-help-americans
[5] https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again

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, a version of which could be established without legislation, 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. We believe that a regular, independent assessment of available data and recommendations based on that data will result in a regular valuation process for E/M care that recognizes its value in keeping Americans healthy. 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 you to support the establishment of a TAC within CMS with adequate funding.**

Support a Robust Primary Care Workforce

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 the most severe in rural and underserved communities.

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.[6] 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.[7] This decline will be exacerbated by a large portion of the primary care physician workforce nearing retirement age[8] as the country's population ages and its health care demands increase. Additionally, retirement rates due to burnout among primary care physicians are increasing and pose significant concerns. **This predicted shortage highlights the urgent need for increased federal investment to train and prepare new primary care physicians who are needed to care for patients with multiple and complex chronic conditions.**

To address the ongoing crisis in primary care, HHS must prioritize policies that support solutions for strengthening the primary care workforce. This should include a comprehensive review of current and projected health care workforce needs, an evaluation of existing federal training programs, an analysis of effective financing mechanisms for health care education and careers, and the development of a strategic plan to eliminate barriers to primary care recruitment and retention. By supporting these efforts, your department can help to strengthen the role of primary care as the cornerstone of high-quality health care in the United States and use federal resources more effectively.

Medicare Graduate Medical Education (GME)

The Medicare GME program is a major public funding source that is central to the training of the physician workforce. According to a Congressional Budget Office estimate, total federal

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[6] https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand

[7] 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

[8] https://www.aamc.org/data-reports/workforce/data/active-physicians-age-specialty-2021

spending for GME in 2018 was more than $15 billion, of which approximately 80 percent or $12 billion was financed by Medicare.[9] **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.**

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.**

Health Professions Training Programs

SGIM recognizes that the administration has announced its plan to move portions of the Health Resources and Services Administration (HRSA) into the new Administration for a Healthy America (AHA) as part of a broader HHS restructuring plan.[10] SGIM appreciates that this new agency will improve coordination of health resources for low-income Americans and will focus on areas including, primary care and workforce development. However, as the administration reorganizes the department, we urge you to preserve workforce programs that support the growth of a well-trained primary care workforce to help Americans prevent and treat the chronic conditions burdening their health. HRSA's Title VII health professions training programs have a history of improving the supply and distribution of the primary care workforce and training the next generation of health professionals to meet our nation's growing health care needs. Specifically, the Primary Care Training and Enhancement program supports a workforce that delivers comprehensive primary care services, which we know leads to more improved health outcomes, lower costs, and better-quality care.[11,12,13] **We urge you to ensure that HHS continues to support programs to help strengthen and expand a well-trained primary care workforce—essential to preventing and managing the chronic conditions affecting millions of Americans, and a goal we know you share.**

Advance Biomedical Research

The National Institutes of Health (NIH) funds foundational, high-risk research that typically is not supported by industry and has been essential in supporting research that advances health care practices. Federal support for NIH supports collaboration across institutions and states, including research networks, other research infrastructure, and training programs. Additionally,

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[9] https://www.cbo.gov/budget-options/54738
[10] https://www.hhs.gov/press-room/hhs-restructuring-doge.html
[11] https://www.healthaffairs.org/content/forefront/primary-care-investment-key-improving-population-health-and-reducing-disparities
[12] https://pubmed.ncbi.nlm.nih.gov/30776056/
[13] https://pubmed.ncbi.nlm.nih.gov/20439859/

the NIH supports research opportunities for the early-stage investigators. Without federal support for the future of the research workforce, we risk cutting off the next generation of researchers.

The NIH launched a pilot program to integrate clinical research with community-based care, which is designed to integrate research findings into clinical practice quickly. Earlier this year, the NIH announced a new funding opportunity to improve patient outcomes and population health by delivering whole healthcare across the lifespan.[14] Research like this is critical to making Americans healthier and reducing the burden of chronic diseases, like diabetes, cardiovascular disease, and kidney disease, chronic diseases that this administration would like to increase investment in.

Furthermore, the Clinical and Translational Science Awards (CTSA)—supported by the National Center for Advancing Translational Sciences (NCATS)—now have hubs at 60 leading medical research centers where they accelerate the translation of biomedical research into improvements in patient care. They provide education, research facilities, biostatistics and study design consultation, informatics support, and many other resources. CTSAs have been national leaders in research education and training, innovations in research design, testing treatments in real-world care, and engaging all stakeholders in the research process, across institutions and disciplines. Since their inception in 2006, CTSAs have provided expert consultations to tens of thousands of researchers, supported the training of thousands of students and fellows, supported the careers of hundreds of junior faculty, and provided research training resources nationally.

Under the President's FY 2026 budget request, the fate of NCATS and the CTSA program is unclear. With a proposed 38% decrease in NIH funding and the consolidation, elimination, and transfer of certain institutes and centers outside NIH, SGIM is concerned that new cures for chronic diseases will not be developed and integrated efficiently into clinical care. **As the future of NIH and the existing institutes and centers is being assessed, SGIM urges you to ensure that any major reorganization advances the agency's mission, is grounded in a clear scientific and policy rationale, and includes input from Congress and key stakeholders.**

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 HHS 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. Primary care research is a form of health services research conducted by members of the care team, with the patients and communities they serve, to translate science into clinical practice. Such research informs policies to improve health outcomes and the value of the care delivered: 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

[14] https://grants.nih.gov/grants/guide/pa-files/PA-24-205.html

initiatives have led to significant financial savings in healthcare systems. For example, Tennessee hospitals saved $17 million by reducing readmissions and safety events from 2012 to 2014. Additionally, AHRQ is a key player in reducing the burden of chronic diseases as the agency has developed evidence-based resources on managing conditions like obesity and diabetes.

AHRQ's 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.[15] Specifically, these investments have focused on heart health, behavioral health and substance use disorders, and care coordination. By focusing on innovative care models, the integration of technology, and the development of a resilient and well-supported primary care workforce, this research aims to transform primary care into a more patient-centered and efficient component of the healthcare system, which is necessary to meet your goal to reduce the burden of chronic diseases.

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. We recognize that HHS has reported that AHRQ will be eliminated as a standalone agency and moved into a new Office of Strategy. **Given the importance of AHRQ's work to primary care and the effectiveness of the healthcare system, we respectfully request that any changes made to the agency as part of the current HHS reorganization preserve AHRQ's essential functions and ensure there is adequate funding to support its research portfolio.**

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

Sincerely,

ESTRADA

Carlos Estrada, MD, MS
President, Society of General Internal Medicine

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