



September 2, 2014

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Department of Health and Human Services  
Attention: CMS-1612-P  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule; Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B Proposed Rule for CY 2015

Dear Ms. Tavenner:

The Society of General Internal Medicine (SGIM) appreciates the invitation to comment on the CY2015 Medicare Physician Fee Schedule proposed rule. SGIM is comprised of approximately 3,500 general internists who provide clinical services and conduct research and educational activities to improve the health of adults, often with multiple complex, chronic conditions.

SGIM particularly appreciates the opportunity to address specific aspects of the proposal and broader aspects of Medicare physician payment policy. SGIM supports the agency's commitment to "ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services." The Society looks forward to working closely with CMS as this proposed rule moves toward implementation and offers the following comments which focus on areas of particular importance to our members:

1. Impact of the RBRVS on Primary Care Payment
2. Valuing New, Revised and Potentially Misvalued Codes
3. Undervaluation of Cognitive-Based Services
4. Evaluation of Global Surgical Packages
5. Elimination of the Refinement Panel
6. Chronic Care Management Services
7. Open Payments Program (Sunshine Act)



### **Impact of the RBRVS on Primary Care Reimbursement**

Our organization's members focus on optimizing health care outcomes in primary care. Primarily based in academic medical centers (AMCs) and affiliated training sites, SGIM members are responsible for educating medical students and residents. Our members conduct health services research, and many focus on innovating medical practice. SGIM members lead many CMS projects testing new delivery system and payment models.

Therefore, our members are intimately aware of how the inequities that have plagued the resource based relative values scale (RBRVS) physician payment have contributed to the relative decline in compensation for primary care and other cognitively-based specialties including neurology, infectious disease, rheumatology, and endocrinology. Transparency, peer review, and evidence-based payment policy are essential elements of a robust and sustainable health care system. However, the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel and its Resource Based Relative Value Update Committee (RUC) processes fall short of these high standards.

SGIM agrees with CMS that RBRVS-based compensation will continue to determine physician payment in all settings (*Fee-for-service will remain a feature of major payment reforms, requiring more changes in Medicare physician payment*. Ginsburg PB Health Affairs 2012; 17: 1977-1983). CMS stated in the CY2015 proposed rule "we also believe that resource-based evaluation of individual physician services will continue to serve as a critical foundation for Medicare payment to physicians whether through the current FFS or in any number of new payment models." Even in new payment models, such as Accountable Care Organizations (ACOs), the inequities of our physician compensation are being recapitulated. As a result, primary care and other cognitively intensive services remain undercompensated.

SGIM remains concerned that enduring deficiencies of RBRVS will erode access to primary care for Medicare beneficiaries. Medical students and residents express interest in primary care, but the income disparity remains a barrier to them entering the specialty. High-performing healthcare systems around the world are based on a robust primary care sector, with the physician workforce evenly split between primary care and specialty services. Only 30 percent of US physicians practice primary care and this proportion will continue to decline as only 20 percent of graduating medical students are expected to enter primary care practice. The last time the US had half of all graduates entering



primary care was in 1998, when average compensation for primary care services was 70 percent that of specialty services. Currently this rate has dropped to only 54 percent, translating to a multimillion-dollar income gap over the career of a primary care physician compared with specialist colleagues. With large medical education debt, residents interested in primary care choose more lucrative specialties; there will not be an expansion of the primary care physician workforce unless there is real and meaningful movement toward income parity.

### **Valuing New, Revised and Potentially Misvalued Codes**

SGIM has concerns about the relationship between CMS' rule making process and AMA's CPT Editorial Panel and the RUC. The Society believes that as long as this impact persists we will not see meaningful reform in reimbursement for cognitive services. While we applaud CMS for examining these processes in the section entitled, *Valuing new, revised and potentially misvalued codes*, but believe that these proposed changes fall short of meaningful reform. CMS addresses the lack of coordination between the CMS rule making process schedule and the schedule for the CPT Editorial Panel and the RUC. The narrative describes the frustration identified by many professional societies due to the lack of timely communication of important deadlines. SGIM, despite its central role in both medical education and health services research, is not allowed to participate in the RUC process because participation is contingent upon membership in the AMA House of Delegates (HOD). HOD membership requires that a threshold number or percentage of society members belong to the AMA. This restriction systematically excludes our organization and others from the processes integral to determining physician reimbursement, including all the advisory committees.

CMS recognizes RUC's organizational policies are exclusionary but fails to express any expectation for change. The CY2015 propose rule states "if stakeholders are not monitoring RUC activities or evaluating Medicare claims data, they may be unaware that these codes are being reviewed and could be reviewed on an interim final basis in a final rule with comment period for a year." Nonetheless, CMS proposes no alternatives to this process, only offering alternatives to address the conflicting schedules and temporary payment ambiguities that result from the conflicting CMS rulemaking and CPT Editorial Panel and RUC timelines. These proposals continue to enfranchise the CPT Editorial Panel and the RUC. SGIM urges CMS consider ways to address the exclusionary practices of the AMA's RUC.



While the AMA is the nation's largest physician organization, it represents fewer than 20 percent of American physicians. The RUC is specialty dominated with permanent "seats" specifically assigned to specialties, such as a plastic surgery, that serve few Medicare beneficiaries. Although more than half of all physician services to Medicare beneficiaries are provided by generalists, the RUC has few primary care representatives and little dedicated representation by specialists in other cognitively intense domains. CMS has allowed the RUC to become the de facto voice for all professional opinion on compensation, despite the systematic exclusion of cognitive professional societies such as SGIM. This process has led to increasing total payments to proceduralists through an expanding number of procedural service codes and higher relative valuations. While SGIM applauds CMS' recent critical stance on RUC valuations, much more needs to be done to address the biases introduced by the RUC process.

If CMS continues to enfranchise the AMA's CPT Editorial Panel and RUC, CMS should establish explicit expectations for representation by all medical subspecialists and representation proportional to the services provided to Medicare beneficiaries. If primary care physicians, those who are most closely involved with the day-to-day health needs of patients, are to advocates for the health and well-being of Medicare beneficiaries, then they should be provided with a proportionate voice in the process that impacts payment for physician services. SGIM believes CMS should not continue to allow the AMA's RUC a stipulated role as an advisory group without changing the nature of that relationship. The AMA claims they are merely exercising their First Amendment protected right of free speech via the RUC, but CMS is not bound by regulation or law to base its payment rate decisions primarily on the RUC.

### **Undervaluation of Cognitive-Based Services**

The relative undervaluation of primary care services extends to the undervaluation of all cognitive-based services. The Relative Value Units (RVUs) assigned to the evaluation and management (E&M) codes are not reflective of the intensity of effort and the value patients derive from cognitive services in contemporary medical practice.

The AMA's CPT Editorial Board, though a separate process from the RUC, has contributed to the undervaluing of cognitive services provided to Medicare beneficiaries. As stated in the CY2015 proposed rule, "the Urban Institute has encountered numerous challenges" in collecting time data for CMS specified services. The Urban Institute found inconsistencies in CPT descriptions of service codes; some services were poorly defined, others referred



to activities that were done by non-physician providers, and others were too vague to parse into specific activities. As a result, Urban was forced to rewrite the specific tasks completed for all of the services.

The Urban Institute's interim report provides clear evidence that the AMA's CPT Editorial Panel has not created a set of code descriptions that can be translated into discrete activities. Having done this outside of the AMA's CPT Editorial Panel, the Urban Institute will attempt to determine independently how much time specific activities take, and, who actually performs each specified activity. For example, if a task is not performed by a physician, then it would be more appropriate to assign this activity as a practice expense. The detail required for this sort of analysis is clearly within the scope of a competent independent contractor. SGIM wonders why the CPT Editorial Panel itself has not previously completed this work, and more importantly, why CMS has not established this as an expectation and been held to this higher standard.

Higher expectations of CPT processes clearly are in the interest of Medicare beneficiaries. Though CMS opens the rule making process up for public review, few Medicare beneficiaries actually understand the nuances of physician compensation. If a beneficiary were to have access to the CPT manual and chose to compare the services he or she has received to the services paid on their behalf by Medicare, it would be very difficult if not impossible due to the imprecision of CPT's current service descriptions.

As noted, the RBRVS will continue to serve as the foundation for physician reimbursement. Therefore, clarity in the definition of each and every service is in the best interests of Medicare beneficiaries and for the agency. CMS must hold the AMA's CPT Editorial Panel to a much higher standard of reliable and accurate service code definition.

### **Evaluation of Global Surgical Packages**

SGIM strongly agrees that the 10- and 90-day global payments for certain service codes are not appropriate. The agency asserts that "the practice reality is that these global codes function significantly differently than other bundle payments." The agency discusses how surgical practice has become more heterogeneous since the original RBRVS deployment in 1992. SGIM is well aware that surgeons and other proceduralists are often not accessible to their patient's for post-procedural care. By default, the primary care physician becomes the provider for post-procedural follow up care. The payment system incentivizes proceduralists to do more procedures, not to provide post-surgical care.



SGIM agrees that the bundling process of "E&M services during post-surgical periods regardless of whether the services are actually furnished" is inappropriate. The service codes, particularly the E&M services that have been bundled in the 10- and 90-day global periods, are different in content and application when delivered as part of the global package than as routine outpatient care.

Currently, there are essentially three outpatient E&M service codes available for established patients, 99213, 99214 and 99215. Each of these service codes has its own pre-, intra-, and post-visit time assumptions. In practice, all of these differ in the surgical and outpatient settings. The CPT Editorial Panel has failed to propose a set of E&M service codes that would be appropriate for post-surgical care of patients on the way to recovery. It is to the advantage of those who practice procedures to use the service codes that are available for all E&M activities. Given the RUC's specialty physician domination, there is an inherent self interest in sustaining the status quo.

CMS will no doubt receive considerable opposition to the elimination of the E&M service codes of global payments. SGIM fully supports CMS's commitment to eliminate the currently existing E&M service codes from the 10 and 90-day bundles but argues that CMS should ask the CPT Editorial Panel to create a new family of post-procedure service E&M codes that are appropriate for these outpatient activities.

SGIM believes that CMS should initiate a process to

- (1) address the failure of the current E&M service code families to encompass the full breath of cognitive activities and create new families as appropriate of surgical follow up;
- (2) appropriately define service code levels within the current and additional families;
- (3) specifically define the service elements (at the detail of the Urban Institute appendix) for the pre-visit, intra-visit and post-visit, including post-visit non face-to-face time related to the face-to-face visit; and
- (4) ultimately appropriately value all E&M services within the RBRVS paradigm.

We plan to submit a second letter formally requesting the agency to embark on this work.

### **Elimination of the Refinement Panel**

SGIM strongly opposes the proposed elimination of the refinement panel. This panel performs an important peer review process that CMS has failed to publicize. In the 1993,



CMS adopted "a refinement panel to assist us in reviewing the public comments on CPT codes with interim final work RVUs for a year and in developing final work values for the subsequent year." To eliminate this, seems contrary to the interests of Medicare beneficiaries and the accuracy of Medicare decisions. The existence of this panel enfranchises the agency with the power to create an alternative to the AMA's RUC. Even if the agency chooses to maintain its close relationship with the AMA, it is appropriate to support and expand the role of the refinement panel.

### **Complex Chronic Care Management Services**

SGIM commends CMS for the creation of service codes to provide physician compensation and practice expense coverage for non face-to-face care management services. Our members' experience with the CMS intensive chronic care management pilot programs clearly points toward the value of care coordination involving physicians, case managers, nurses, social workers and others with a specific intent of improving health outcomes and reducing Medicare costs.

SGIM agrees with the proposal to eliminate the required practice capabilities. We concur with CMS that the existing requirements for electronic health records are sufficient to support the needs of this CCM codes without additional detailed stipulations. The creation of an additional set of practice standards will further complicate an already overlapping set of practice expectations.

SGIM is deeply concerned by the inadequacy of the proposed practice expense payment. Currently, the PE RVUs are 0.57 for non-facility, 0.26 for facility. These numbers will not cover the salary support necessary for the services expected and needed. The current proposed payment for non-facility care management would grossly under support these activities as they are currently designed.

This concern is based on the following analysis:

- Assuming that a care manager works 50 weeks per year, 40 hours per week and 60 minutes per hour and that care requires 20-minute sessions per beneficiary. The total number of 20 minute segments per year works out to 6000. Assuming that roughly half of the care manager's time is consumed by pre and post-encounter work (roughly equal to the pre and post face-to-face time of an E&M service code) that would yield roughly 3000 individual segments per calendar year.



- At current Medicare payment rates of \$35.82 per RVU, this would yield \$107,460 of total payment per year. Assuming that overhead is at least 50%, this would yield a total payment of \$53,730 per year. Assuming a 30% fringe rate, this would yield an annual salary of \$37,611. This is roughly one-third of the current nurse payment level in most metropolitan areas. The current proposed payment for non-facility care management would grossly under support these activities as they are currently designed.

Within a facility-based primary care practice, the payment would cover a fraction of what is required. Most primary care practices based in facility settings are required to cover their overhead. The amount of cross subsidization from hospital to outpatient practices has dramatically declined, and therefore, the payments available to provide for care management at facility based programs would not be sufficient to attract the administrative and infrastructure support for these codes.

SGIM asserts that the current use of time metrics for code documentation is inefficient and impractical. The experience with care management indicates that multiple short phone calls add up over a one-month period. If the care manager is required to provide documentation repeatedly during the day, the work flow will be disrupted to the detriment of the care delivered to patients. Since multiple providers may be involved in the care of patients, it becomes even more difficult to keep track of the time allocations. This administrative burden will limit the value of care management.

The care management needs of beneficiaries vary considerably from month to month. The average might be 20 minutes per beneficiary per month, but there are some months where a 5-minute phone call is all that is necessary to assure that a patient is stable. There are other months where an hour or more of telephone contact will be required to resolve conflicts and improve patient outcomes. The requirement of 20 minutes per beneficiary per month imposes an unrealistic expectation that will challenge practices and foster unnecessary phone calls and documentation. This will detract from the care of those patients who require extended intervention.

CMS should consider adopting the CPT codes for CCM rather than the proposed G-code. Besides addressing our concerns about the reimbursement level CMS set for the G-code, adopting the CPT codes for CCM would help achieve CMS' stated intentions of driving



delivery system transformation. CPT codes can be used by any payer, not just by Medicare. The adoption of the CPT codes for these services would ensure that all payers can start reimbursing physicians for these non-face-to-face services driving these reforms beyond the Medicare system.

If CMS does not adopt the existing CPT codes for the CCM services, we recommend that the agency begin the development of an add-on code that can be billed in conjunction with CMS' G-code. The creation of an add-on code would allow for the work physicians do for more complex patients than those described in the G-code to be adequately reimbursed.

In summary, SGIM would propose the following:

- (1) that the practice expense component of the service code should be at least doubled from the current value;
- (2) that facility practice expense be increased to 80% of the non-facility;
- (3) that the time based service expectation be eliminated; and
- (4) that CMS adopt the CPT codes for CCM rather than the proposed G-codes. The detailed care management plan will fully meet Medicare's requirement for documented values for the service code payment.

We urge CMS to focus on developing a best practices guide for care management plans to assist the physician community.

#### **Open Payments Program (Sunshine Act)**

CMS is proposing to revoke the Sunshine Act reporting exclusion for continuing medical education (CME) activities. The proposal would exempt third party transfers for CME only in circumstances where the industry donor is unaware of the recipients before and after the funds are transferred. We believe that this proposal is not only unworkable, but will have a detrimental impact on continuing education activities.

SGIM believes that industry donors will often be able to learn the identities of speakers and participants through brochures, programs, other publications and physician employees who participate. This will directly impact the Society and ultimately the public whose physicians will not be educated on state of the art medical practices.

SGIM urges CMS not to implement this provision as written. We recommend that the exemption apply if a manufacturer provides funding for CME and is not responsible for



selecting or paying the speaker or faculty directly or provide the continuing education provider with a distinct, identifiable set of cover recipients to be considered as faculty. Most importantly, CMS must specify that the exemption is satisfied as long as the industry sponsor is unaware of the CME faculty prior to committing to fund the course.

SGIM looks forward to continuing to work with you to finalize these proposals in order to ensure physicians are providing the highest quality care to Medicare beneficiaries.

Thank you again for the opportunity to comment on this proposal. If you have questions or require further information, please contact Erika Miller at 202-484-1100 or [emiller@dc-crd.com](mailto:emiller@dc-crd.com).

Sincerely,

A handwritten signature in black ink, appearing to read "W. P. Moran", is written in a cursive style.

William P. Moran, MD, MS