

***A Statement from America's Primary and Comprehensive Care Physicians:
Congress Should Support Medicare's Plan to Pay More for Office Visits and Other Essential Services
October 20, 2020***

Our organizations represent hundreds of thousands of physicians who furnish the vast majority of primary, comprehensive, and cognitive care to American adult and elderly patients including diagnosing and treating millions of patients and their families for COVID-19. We urge Congress to support the Centers for Medicare and Medicaid Services (CMS) implementation of 2021 Medicare Physician Fee Schedule, scheduled to go into effect on January 1, 2021, as this rule will make historic improvements to Medicare physician payment policies for outpatient comprehensive primary and cognitive care at a time when practices are under severe financial stress and at risk of closing due to lost revenue from COVID-19.

Most importantly, these updates will help the tens of millions of Medicare patients who rely on physicians in this coalition not only for outpatient diagnosis and treatment of COVID-19, but also to make up for delays in getting preventive treatment, vaccinations, and services to manage their chronic conditions during the months when they were unable to receive care at their doctor's office. The bottom line is that the changes outlined below merit Congress' strong support as they will improve care by allowing physicians to spend more time with their patients.

1. **Congress should urge CMS to move forward with fully implementing the increased payment for outpatient evaluation and management services and other improvements in the 2021 proposed and previously finalized Medicare Physician Fee Schedules. These improvements include:**

A. Increased Valuation and Payments for Outpatient Evaluation and Management (E/M) Services: Medicare has long undervalued E/M services, such as office visits and care management services, in the Medicare Physician Fee Schedule (MPFS). Such services are predominantly provided by physicians who are included in this coalition, although many other specialists also provide E/M services. The direct result is fewer physicians going into primary care and related cognitive disciplines, as well as barriers to accessing care for patients. In the CY 2020 MPFS final rule, which was published in November 2019, CMS finalized greatly improved relative values for most new and established patient office visits based on recommendations of the Specialty Society Relative Value Scale Update Committee (RUC), an advisory body chaired by the American Medical Association that makes recommendations about the value of physician services to CMS. The increase reflects the results of a RUC survey of more than 50 specialty societies that agreed that Medicare does not properly value patient office visits (among the most important E/M services) and that they are generally more complex for most physicians than previously valued. It is important that there are accurate and appropriate reimbursements for all E/M services across the board, especially all primary care services, including home-based primary care (HBPC) E/M services. In the CY 2021 proposed rule, CMS indicates that they are planning to move forward with these improvements to outpatient E/M services after seeking and incorporating feedback from the medical community for three years. *However, much of the expected payment increases for outpatient E/M services has been negated due to budget-neutral adjustments. Because of budget neutrality requirements, payments for many other services performed by our members will also be cut. Budget neutrality adversely affects physicians in every specialty—including primary care, medical specialists, and surgeons. We also emphasize that these changes are only a first step to appropriately describe non-procedural care, and CMS must continue this work by addressing the documentation and valuations of the inpatient E/M services using an evidence-based approach.*

B. Implementation of a proposed new billing code, known as the GPC1X code, which would provide increased payment for complex care inherent to some of the office visit codes. The addition of GPC1X is essential to the recognition of the complexity of caring for patients with chronic conditions such as cancer, dementia, or diabetes—and in many cases, multiple chronic illnesses—that require primary care physicians and medical subspecialists to spend more time diagnosing and coordinating care for these patients. Without this add-on code, office visits provided by primary care and medical specialists will continue to be undervalued. This is especially important at a time when many patients with chronic illnesses delayed seeing their physicians because of COVID-19 and are now presenting with much more complex problems. The proposed code is appropriately being reviewed during the comment period on the 2021 Medicare Physician Fee Schedule with opportunities for all specialties and the public to submit comments. Congress should express to CMS its support for finalizing the new code, and not take any legislative action that would delay or halt implementation of the code on January 1, 2021.

- C. ***Higher Payments for Vaccine Administration:*** CMS proposes to significantly increase payments to physicians for administration of immunizations, which is critical to ensuring physicians can administer and counsel patients on vaccines for COVID-19 when they become available, and administer other essential vaccines, including for patients who may have delayed getting vaccinated because of the pandemic.
- D. ***Additional Payments for Care of Advanced End Stage Renal Disease (ESRD) Patients:*** CMS proposes to finalize implementation of additional payment for physicians who treat patients with chronic kidney disease that has reached an advanced state. These patients require dialysis or a kidney transplant to live.
- E. ***Payments for Transitional Care Management Services:*** CMS is also proposing to increase payments for transitional care management services to physicians for patients with complex care management needs, changes that if finalized will allow physicians to better coordinate and manage the care of these patients, leading to better outcomes.
2. **Congress should ensure that any proposed legislation to address the cuts for some services resulting from budget neutrality (BN) is fair to all services and specialties, does not distort relative values and actual payments as determined through the usual regulatory process with public comment and input from physicians, and does not disadvantage primary and comprehensive care services compared to other services. Congress should also avoid a temporary legislative fix that would create a future “funding cliff.” The following approaches could achieve such an outcome:**
- A. Enacting a one-time, one-year waiver of BN for all services with RVUs or base values as finalized in the 2021 MPFS, or
- B. Enacting a one-time, one-year COVID-19 percentage payment adjustment to all services with RVUs or base values as finalized in the 2021 MPFS, in an amount sufficient to offset reductions due to BN, recognizing that all specialties, including primary and comprehensive care physicians and surgeons, have experienced substantial revenue losses and increased expenses due to COVID-19, and
- C. Urging or directing HHS and CMS to use their existing public health authority, or unused Provider Relief Fund dollars, to pay for a BN waiver or COVID-19 payment adjustment, or enacting legislation to accomplish the same.
3. **Congress should not interfere with the CMS regulatory process that determines payment for global surgical services.** Congress has requested that CMS conduct a study to determine if the global surgery bundle is accurately valued, including whether postoperative E/M visits are valued appropriately. CMS has reviewed the evidence, as directed by Congress, and proposed values for the E/M services included in the global surgery bundle that appropriately recognize the work involved. We believe Congress should not seek to override CMS’s findings from the study that Congress itself directed. We also agree with the Medicare Payment Advisory Committee (MEDPAC) report that showed that “the global payment rate assumes that the same physician who performs the procedure also provides all the postoperative care, such as E&M visits. However, a study by the RAND Corporation observed that postoperative care is shifting from the physician who performed the procedure to other clinicians, such as hospitalists and non-physician practitioners, who bill separately for each postoperative visit. This change suggests that physicians who bill for a global surgical service may be receiving payments for postoperative visits that in reality are provided by other clinicians.”

Should Congress consider any future changes to the Medicare Physician Fee Schedule, we ask that you consider our recommendations to ensure that these improvements in Medicare payments for primary, cognitive, and comprehensive care are preserved, and that improvements to inpatient cognitive care are pursued, while addressing the impact of budget neutrality and COVID-19 in a way that recognizes its adverse impact on all physicians and patients, is fair to all, and does not distort underlying payment policies.

American Academy of Allergy, Asthma, and Immunology, American Academy of Home Care Medicine, American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American College of Rheumatology, American Gastroenterological Association, American Geriatrics Society, American Medical Society for Sports Medicine, American Psychiatric Association, American Society of Hematology, American Society of Nephrology, American Thoracic Society, Endocrine Society, Infectious Diseases Society of America, North American Neuro-Ophthalmology Society, Renal Physicians Association, Society of General Internal Medicine, The Society for Post-Acute and Long Term Care Medicine