AMERICAN ACADEMY OF FAMILY PHYSICIANS

February 2, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Re: Full Implementation of Medicare G2211 Add-on Code in 2024 Medicare Physician Fee Schedule

Dear Administrator Brooks LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing 127,600 family physicians and medical students across the country, I write to share recommendations for consideration as the Centers for Medicare and Medicaid Services (CMS) begins work on the calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) proposed rule.

In the 2021 MPFS, CMS finalized the creation of code G2211 to describe the complexity inherent to office/outpatient evaluation and management (E/M) visits associated with primary care and other types of ongoing care (specifically, E/M visits associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition, regardless of the specialty of the billing professional). CMS finalized this code alongside the 2021 updates to the office/outpatient E/M codes, noting that it was an important addition to ensure relativity within the MPFS. **The AAFP applauds CMS for recognizing additional complexity inherent in the delivery of continuous, comprehensive, coordinated primary care, as well as other ongoing services, and taking steps to improve fair valuation and payment for these services under the MPFS.**

Before G2211 was implemented, Congress placed a statutory moratorium on its implementation until December 31, 2023. As a result, CMS placed G2211 in "bundled" status for CY 2021-2023, meaning physicians could bill the code but not be paid separately for it. The statutory restriction on the implementation of G2211 will no longer be in place as of January 1, 2024. **The AAFP strongly supported the creation of G2211 and urges CMS to ensure its full implementation in CY 2024.** Below we detail our rationale for our ongoing support of G2211, including:

- **Evidence demonstrates that continuous primary care is more complex, comprehensive, and impactful. G2211 is needed to better account for the unique costs of providing this important longitudinal care relationship.**
- **While the updated office/outpatient E/M codes more appropriately value the care provided during an office visit, the existing processes for creating, describing, and**

valuing these codes do not account for unique costs borne by primary care and other physicians providing longitudinal, patient-centered care.

- **Given the above concerns, G2211 is needed to maintain relativity in the Medicare Physician Fee Schedule.**
- **Implementing G2211 will advance several of CMS' strategic priorities by stabilizing and strengthening community-based primary care practices, increasing connections to primary care, and addressing health disparities.**

The AAFP also reiterates our recommendations for revising the accompanying utilization assumptions and estimates for G2211.

Primary Care Office Visits are More Complex, Comprehensive, and Impactful

Primary care is the provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.

Evidence clearly demonstrates that primary care office/outpatient E/M visits are more complex and comprehensive than other E/M visits. The existing CPT and RUC methodologies for creating, describing, and valuing E/M services do not account for this additional complexity and comprehensiveness, leaving a gap in office-based coding in the MPFS that must be filled by G2211.

A study published in *Healthcare* in 2015 found that family medicine and general internal medicine encounters were more complex compared to other specialties, especially when the duration of visit is considered.[1] This complexity is due to higher quantities of care (i.e., patient complaints and characteristics, as well as treatments prescribed), high diversity in care inputs and outputs, and high complexity density, meaning primary care physicians pack highly complex care into brief visits, ultimately intensifying the overall workload. The authors note this is consistent with primary care physicians' role in managing multiple chronic problems, balancing multiple guidelines, registries, and interdependent disorders, and coordination of care across several clinicians. While the recent revisions and revaluations of the office E/M codes better enable primary care physicians to bill for this complexity, they still do not account for many of these unique costs, like coordinating care across several clinicians. Below, we further explain how the existing CPT and RUC processes focus on "typical" patients across all types of office E/M visits and therefore undervalue the highly complex work of primary care.

Primary care doctors play a crucial role in coordinating care for their patients, as they are responsible for managing the overall health care of individuals with multiple conditions. This often requires communicating with a variety of specialists, including cardiologists, neurologists, psychiatrists, and surgeons as well as pharmacists and social workers. In contrast, specialists typically focus on a specific area of medicine and do not have the same level of coordinating responsibilities as primary care physicians. According to a study in *Annals of Internal Medicine*, the typical primary care physician caring for Medicare patients must coordinate care with 229 other physicians working in 117 practices.[2]

The complexity and comprehensiveness of primary care are undervalued in the current E/M system but invaluable to the nation's health. Primary care positively impacts health equity, access to care, and health outcomes, and it is the only medical specialty that has repeatedly demonstrated these attributes.

- The seminal research led by Barbara Starfield validated that those individuals with access to primary care have better health outcomes and lower mortality rates than those who do not.[3]
- A subsequent study found that the number of primary care physicians in an area is associated with lower mortality rates at the population level.[4] No other specialties studied in these articles were found to be associated with lower mortality on a population level. Two other studies found that better continuity in primary care can reduce mortality, health care expenditures, and hospitalizations.[5,6]
- Primary care has also been shown to improve access to care for underserved populations and reduce health disparities.[7]

Overall, the evidence confirms that investing in primary care can lead to better health outcomes and more equitable access to care for all individuals.

Existing Codes and Code Development Processes Do Not Account for the Work Valued by G2211

The AAFP acknowledges and appreciates that the Current Procedural Terminology (CPT) Editorial Panel has made a concerted effort in recent years to revise the E/M section of CPT in ways intended to ease administrative burden and focus more on medical decision making. The AAFP also acknowledges and appreciates the effort the Relative Value Scale Update Committee (RUC) and CMS have put into revaluing the E/M codes as revised by CPT. All these efforts have resulted in significant improvements to the description and valuation of E/M services.

Despite those important changes, the AAFP believes G2211 is still needed, because the CPT and RUC processes did not capture the work represented by G2211. The AAFP makes this point not to be critical of the CPT or RUC process, per se. As noted, the AAFP acknowledges and appreciates the work of both bodies in improving the description and valuation of E/M services in recent years. However, neither process is perfect, and the AAFP points out some of the imperfections in each process to illustrate why the AAFP believes CMS is fully justified in implementing G2211 as part of the 2024 Medicare physician fee schedule.

For instance, CPT describes levels of office/outpatient E/M codes based only on time and medical decision making, which CPT divides into:

- Number and Complexity of Problems Addressed at the Encounter
- Amount and/or Complexity of Data to Be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

However, under the resource-based relative value scale, “work” is understood to be a product of time and “intensity.” “Intensity,” in turn, is understood as a function of:

- Mental effort and judgment (possible diagnoses and management options, amount/complexity of data to be considered, and urgency of medical decision making)

- Technical skill
- Physical effort
- Psychological stress (risk of complications/morbidity/mortality, outcome dependent on skill/judgment of physician, and estimated risk of malpractice suit with poor outcome)

"Intensity" is broader than medical decision making and encompasses elements of work not considered in the CPT E/M descriptors. For example, some office/outpatient E/M services are more urgent than others, and some require more technical skill with respect to the physical exam, but CPT makes no distinctions in that regard.

The AAFP also observes that CPT is better at describing discrete procedures than continuous, comprehensive primary care. There are at least 23 CPT codes (44388-44408 and 45378-45398) that describe colonoscopy. Meanwhile, there are only nine CPT codes to describe office/outpatient E/M services, despite the fact office/outpatient E/M services are done hundreds of millions of times and represent a much wider and more diverse range of diagnoses than does colonoscopy. These nine CPT codes also only consider services provided within a given time frame before, during, and after an office/outpatient encounter. The provision of comprehensive, coordinated, longitudinal primary care is inherently not tied to single encounters and encompasses additional physician work and encompasses additional services throughout the year, outside of the timeframes described by CPT and valued by the RUC for the E/M codes.

The RUC is equally challenged to capture the work of primary care in its current process of valuing E/M services. There are two ways in which this happens. First, the RUC survey process focuses on the "typical" patient and distributes surveys based on vignettes for E/M services that are much less specific, making it more difficult to quantify the physician work involved than for more specific procedural service vignettes.

For example, the "typical" patient vignette for the most recent survey of code 99214 read, "Office visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment." Compare this with the vignette for 45379 (Colonoscopy, flexible; with removal of foreign body(s)): "A 50-year-old patient with abdominal pain and constipation swallowed a diagnostic capsule, which became lodged at the ileo-cecal valve. Colonoscopy with removal of the foreign body is performed."

Second, this problem is compounded when these broad E/M vignettes are surveyed across more than 50 specialty societies, many of which do relatively few and much more straight-forward E/M visits than primary care. This approach under-values the input of the primary care specialties that provide the most complex E/M services and do so most commonly. In 2021, code 99214 was the most common office/outpatient E/M service billed to Medicare. Internal medicine and family medicine billed this code most commonly, composing almost a third of the total Medicare volume, with nurse practitioners, many of whom work in primary care, providing another 11 percent of the volume.

Consequently, the AAFP believes the RUC E/M valuation process did not fully capture the complexity of the work of primary care, which is why implementation of G2211 is necessary.

The AAFP believes these points are consistent with observations that CMS itself made when it originally finalized G2211 in the final rule on the 2021 Medicare physician fee schedule. In that rule, CMS stated:

> *Although we believe that the RUC-recommended values for the revised office/outpatient E/M visit codes will more accurately reflect the resources involved in furnishing a typical office/outpatient E/M visit, we continue to believe that the typical visit described by the revised and revalued office/outpatient E/M visit code set still does not adequately describe or reflect the resources associated with primary care....*

CMS went on to state:

> *We continue to believe that the time, intensity, and PE involved in furnishing services to patients on an ongoing basis that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape, are not adequately described by the revised office/outpatient E/M visit code set.*

The AAFP wholeheartedly agrees with CMS on both accounts. **Primary care is comprehensive, continuous, and coordinated team-based care that is not adequately described by the revised office/outpatient E/M visit code set and includes resources not reflected in in the current relative values assigned to that code set.**

Beyond the revision and revaluation of the office/outpatient E/M codes, CPT, RUC, and CMS have facilitated the creation, valuation, and implementation of codes for transitional care management (TCM), chronic care management (CCM), and principal care management (PCM). Some have argued that TCM, CCM, and PCM codes can handle extraordinary cases where office/outpatient E/M codes and values are insufficient and that PCM, CCM, and TCM otherwise represent the intent of G2211.

As CMS noted in the CY 2021 MPFS final rule, PCM, CCM, and TCM all have limitations that prevent them from filling the role intended for the more broadly applicable G2211. For instance, PCM codes are limited to patients with a single high-risk disease (i.e., one complex chronic condition) and include other requirements that limit their utility in primary care. CCM codes are limited to patients with two or more chronic conditions and include other requirements that also limit their utility. TCM codes are limited to patients experiencing a discharge from the hospital/facility setting and focus on care management for 30 days following a discharge rather than the time, intensity, and practice expense involved in furnishing services to patients on an ongoing basis.

In comparison, as CMS also noted in the CY 2021 MPFS final rule, code G2211 reflects the time, intensity, and practice expense when primary care physicians and their teams furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. Evidence confirms all patients benefit from greater care continuity.[8,9] Thus, PCM, CCM, and TCM do not address the inherent problems in the CPT and RUC processes that work against proper description and valuation of primary care E/M services. G2211 is needed to appropriately value the unique costs of care continuity and longitudinal care for all beneficiaries.

Implementing G2211 is Needed to Restore the Relativity of the Fee Schedule

The MPFS uses the resource-based relative value scale (RBRVS) which is based on the principle that payments for services should vary with the resource costs of providing those services. CMS is charged with maintaining the relativity of the MPFS, or ensuring that payment for services that require more resources to furnish are higher than for services that require fewer services. Based on the evidence we have presented, it's clear G2211 is still needed to better account for the unique costs of providing continuous care, like the longitudinal primary care services regularly provided by family physicians. As CMS noted in the CY 2023 MPFS and we reiterated above, the existing E/M code sets are designed to be used by all types of clinicians and do not include payment for ongoing care coordination and follow-up. Therefore, the E/M code sets fail to capture the relativity of E/M services that are part of ongoing, continuous care. **Implementing G2211 will advance the relativity of the MPFS and better account for the resource costs of providing high-quality, longitudinal primary care.**

Implementing G2211 Will Advance CMS' Strategic Framework

Implementing G2211 will advance HHS' and CMS' strategic pillars of advancing health equity, expanding access, and driving innovation. The National Academies of Science, Engineering, and Medicine recently urged policymakers to significantly increase investment in primary care, noting that primary care is the only health care component for which increased supply is associated with more equitable health outcomes.[10] Primary care physicians leverage their longitudinal patient relationships (and relationships with other care providers and organizations in their community) to address patients' unmet health-related social needs, effectively promote the utilization of high-value preventive services, and promote healthy behaviors – all while taking into account the available resources in their community. As we've noted, the Medicare Physician Fee Schedule does not currently pay for the physician work involved in maintaining these longitudinal relationships, providing personalized care, and coordinating across the care team. G2211 is an investment in longitudinal person-centered primary care services that improve individual patient wellbeing and address disparate health outcomes.

Taking this step to more appropriately value primary care will help stabilize the primary care workforce, especially community-based primary care practices Medicare beneficiaries rely on for their care. In turn, this will help prevent practice closures and consolidation, which can negatively impact beneficiary access, care quality, and affordability.[11] Supporting community-based primary care practices in delivering high-value, person-centered care will improve beneficiaries' access to care in their own communities. Although the results are mixed, some evidence from the Affordable Care Act's Medicaid primary care fee bump indicates that increasing payment for primary care services can increase appointment availability and improve health outcomes.[12] Low-income patients and their physicians have also reported that low payment rates lead to shorter, inadequate visit times. Implementing G2211 has the potential to reduce appointment wait times and enable physicians to spend more time with their Medicare patients.

As we noted in our comments on the CY 2023 MPFS, primary care practices are struggling to transition into value-based care models at current fee-for-service (FFS) payment levels. Successful participation in alternative payment models (APMs) like Medicare Shared Savings Program

Accountable Care Organizations (ACOs) or Primary Care First (PCF) require significant upfront investment in technology and staff. Primary care practices that are struggling to keep their doors open cannot possibly make these investments. By more accurately paying for the unique costs associated with providing longitudinal primary care, implementing G2211 will help these practices invest in the staff and tools they need to transition to an APM. Given that most APMs are built on a FFS chassis, implementing G2211 will also ensure payment rates in APMs are sufficient and fully supporting the provision of high-quality primary care.

CMS Should Revise G2211 Utilization Assumptions for 2024 Rulemaking

Finally, **the AAFP urges CMS to revise its utilization estimates for G2211 in CY 2024.** In the CY 2021 MPFS final rule, CMS assumed that G2211 would be billed with 90 percent of office/outpatient E/M codes provided by family physicians and other specialties that provide primary care or certain types of specialty care. This utilization assumption was reduced by 10 percent from the proposed rule due to feedback from commenters that it would take time to educate physicians and others about the availability and appropriate use of G2211. CMS noted that it had not finalized policies to restrict the billing of G2211. The AAFP continues to believe this utilization assumption is unrealistic and should be modified.

CMS should base utilization estimates for G2211 on actual utilization of similar new codes that were implemented in recent years. For example, CMS could examine the utilization of CCM, PCM, and TCM codes among eligible patients in their first year of implementation. A recent study found that, in 2016 (the second year of implementation) 2.3 percent of Medicare beneficiaries had claims for chronic care management services even though two thirds of beneficiaries were eligible for such services.[13] The same study found that 22 percent of Medicare beneficiaries were eligible for TCM services but only 9.3 percent of eligible beneficiaries had claims for TCM filed.[14]

The AAFP further notes that family physicians in certain settings will have encounters with some patients that are not part of continuous ongoing care and therefore they will not bill G2211 with every office/outpatient E/M encounter. For example, some family physicians practice in urgent care centers or walk-in retail clinics that are specifically designed to address acute health care needs without coordination or follow-up, which will often be provided by a patient's usual primary care physician. We further believe many of the specialties CMS has assumed will use the G2211 code will regularly have encounters with patients that are not part of continuous care related to a single serious condition. While specialty encounters with patients may be part of ongoing care, many such encounters will be only for the purpose of determining if a patient has an acute or chronic condition that requires further treatment. When a diagnosis is not made and further treatment or follow-up isn't required, the encounter would not be related to ongoing care. We strongly urge CMS to modify its utilization assumptions to account for these considerations. CMS notes in the final rule that the use of G2211 could be audited using claims data to determine if ongoing care is provided or whether the patient has a single serious condition. Even without explicit policies restricting the use of the code, we believe practitioners will limit their use of G2211 to patients and encounters for which it is clearly appropriate to bill in order to protect against audits or other concerns from CMS. The evidence we previously presented about the historic use of CCM and TCM confirms this.

We urge CMS to reexamine its utilization assumptions based on implementation experience with other new codes and the examples we provide above. We believe doing so could reduce CMS' utilization estimates, the resulting increase in Medicare spending, and ultimately the budget neutrality adjustment CMS will apply in the CY 2024 MPFS. Given the potential redistributive impact of this budget neutrality adjustment on specialties that do not regularly provide longitudinal care, it is imperative that CMS' utilization estimates be as realistic as possible.

The AAFP greatly appreciates CMS' ongoing work to continually invest in and pay appropriately for comprehensive, longitudinal primary care. Finalizing G2211 represented a significant step toward ensuring a fair and accurate MPFS and the AAFP stands ready to partner with CMS to ensure successful implementation in CY 2024. Thank you for your consideration of our recommendations. Should you have any questions, please contact Meredith Yinger, Manager, Regulatory Affairs at myinger@aafp.org or (202) 235-5126.

Sincerely,

Sterling N Ransone, Jr MD FAAFP

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

Cc: Dr. Meena Seshamani, Deputy Administrator and Director of the Center for Medicare
Jon Blum, Principal Deputy Administrator and Chief Operating Officer

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