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Regarding: Medicare Physician Fee Schedule Proposed Rule, HCPCS Code GSMAS

Submitted to: Centers for Medicare & Medicaid Services (CMS)

Submitted by: Paula Gardiner, MD, MPH and Jeffrey S. Geller, MD

Executive Summary

On behalf of the Integrated Center for Group Medical Visits (ICGMV), thank you for allowing us to comment on the HCPCS Code GSMAS. The Integrated Center for Group Medical Visits (ICGMV), founded in 2019, is a nonprofit clinical, educational, and research organization dedicated to advancing Shared Medical Appointments (SMAs) and/or Group Medical Visits (GMVs) as evidence-based models of care. For the purposes of this letter, we will refer to them as SMAs. ICGMV, was founded by Dr. Geller, a primary care physician, who has been delivering SMAs for over thirty years in Lawrence MA. He is considered one of the national originators and leaders of the modern group visit models. Dr. Gardiner, a clinical researcher and primary care physician has been studying the SMA model since 2007. She also offers SMAs to her primary care patients at Cambridge Health Alliance.

Both Dr. Geller and Dr Gardiner have been providing educational training separately and together for the last 30 years on SMAs regarding curriculum development,financial sustainability, facilitation, group dynamics, evaluation, staffing, promotion, infrastructure, and institutional buy-in. The ICGMV provides direct patient services, clinician training, implementation support, research, and national educational programming focused on improving chronic disease outcomes, addressing social isolation and loneliness, and expanding access to whole person care through group-based medical visits. The organization serves as one of the nation's leading centers for the training and evaluation of SMA and GMV models. To see a list of all the SMAs occurring at the center click here.

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We support creation of HCPCS code GSMAS and establishment of a Medicare reimbursement pathway for SMAs. However, we recommend CMS preserve the core features responsible for SMA effectiveness: broad condition eligibility, medication management, flexible duration, appropriate group size, more than one providers' participation, equitable reimbursement, and inclusion of FQHCs and RHCs.

Background

SMAs combine individualized high quality clinical care with patient education, self-management support, behavior change counseling, and peer learning. We have witnessed the SMA as a high quality model to deliver care in outpatient settings and inpatient settings. We have trained over 3000 clinicians, who have successfully implemented SMAs in diverse clinical settings with medically diverse populations.

Dr. Geller currently leads one of the largest Shared Medical Appointment (SMA) programs in the United States, conducting more than 34 SMAs each week across a diverse range of clinical conditions and patient populations. These visits represent over many different types of SMAs including: first, skill building and patient education such as nutrition or osteoporosis SMAs, other SMA provide services such as a chair Yoga to prevent falls or acupuncture for patients with chronic pain. Additionally, our SMAs provide primary care such as SMAs for diabetes or hypertension called Lifestyle fit and wellness exams (vaccinations and preventative screening). Mental health SMAs for ADHD are co-facilitated with a prescribing clinician and mental health clinician. SMA for treatment of addiction such as a suboxone group. Pediatric empowerment SMAs treat childhood obesity and provide support and encourage building new skills. SMAs such a GLP-1 group for weight loss, sleep apnea and diabetes allow patients to be efficiently treated. We provide SMA for acute care such as a drop in group for people with poorly controlled blood pressure, diabetes, or poorly controlled pain. In our professional opinions, SMAs reduce loneliness in our patients and increase community resources and peer support. We recently had a 30th year of SMA celebration hosted by our patients. They could not express enough how important it was for them to feel that they had a home with peer support. It was obvious how medical care in a group setting helps people heal and connect in a way that improves outlook and empowers lifestyle changes.

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We also offer condition-specific programs supporting patients using GLP-1 medications for obesity and diabetes management. Mental health SMAs for ADHD are co-facilitated by a prescribing clinician and a behavioral health professional.

CMS Comment 1: Appropriate Conditions to include in SMAs

We recommend CMS not restrict SMAs to conditions deemed lifestyle-modifiable. Systematic reviews and randomized trials demonstrate benefits across numerous chronic conditions. Diabetes is the most extensively studied condition with approximately 47 studies demonstrating improved glycemic control and self-management. Hypertension, heart failure, obesity, COPD, osteoporosis, migraine, chronic pain, depression, cancer survivorship, Parkinson disease, rheumatoid arthritis, neuromuscular disease, prenatal care, and additional chronic conditions also have published evidence supporting SMA implementation. More than fifteen chronic conditions have published SMA evidence. Most Medicare beneficiaries participating in SMAs have multiple chronic conditions, making diagnosis-specific restrictions impractical and inconsistent with real-world care.

CMS Comment 2: Duration

We recommend CMS should allow duration to be based on clinical need rather than a fixed 60-minute requirement.

Though many group models exist in the 60 minute time frame and that is the model at ICGMV. The literature generally supports sessions of 90 to 120 minutes. Examples include Morone et al. (120 minutes), Gardiner et al. (150 minutes), Baqir et al. (90 minutes), and Yancy et al. (90-120 minutes). If a time restriction is required, we recommend expanding to include longer 90 minute sessions. The 90-minute duration is common in the original SMA model descriptions and in specialty settings, whereas many diabetes and cardiovascular trials have gravitated toward 2-hour

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sessions to accommodate education, group discussion, and individual clinical encounters. Randomized controlled trials of SMAs report session length of approximately 90 minutes to 2 hours (Bronson and Maxwell 2004, Wu et al. 2017, Tang et al 2024,. Edelman et al 2015), approximately 1.5–2-hour group medical visits for diabetes with intensive weight management (Yancy et al. 2020), and 120-minute mindfulness-based group medical visits for chronic low back pain (Morone et al. 2026); this range should therefore be regarded as the evidence-supported operating window rather than a fixed regulatory minimum

For many SMAs, clinicians bill by medical complexity, allowing them to spend the appropriate amount of time based on providing high-quality standards of care and reducing medical errors. Since SMAs are focused on the prevention and treatment of chronic conditions, clinicians require sufficient time to provide individualized patient clinical assessment and the beneficiary's proportionate share of group education, counseling, and peer support. Therefore, 60 minutes can be too restrictive and may decrease the quality of individual care required.

CMS Comment 3: Group Size

We recommend providing clinicians with flexibility in the number of patients they schedule in a SMA.

The 15-patient range for SMAs is supported by the clinical trial evidence across chronic conditions, cost-effectiveness modeling, group dynamics research identifying the need for a critical mass to activate peer support mechanisms. This range represents the evidence-base clinical outcomes, patient satisfaction, cost-effectiveness, and operational sustainability.

Evidence supports group sizes around 15 participants. Given approximately 23% outpatient no-show rates, programs frequently over-enroll to achieve appropriate attendance. Restricting groups to a maximum of 10 patients may undermine peer support, operational feasibility, high quality medical care, and financial sustainability. The evidence from clinical trials on patients with chronic conditions consistently demonstrates that SMAs achieve optimal outcomes when

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groups include at least 15 patients per session. This is supported by converging evidence from clinical effectiveness, group dynamics, cost-effectiveness, and operational feasibility perspectives. The most robust clinical outcomes were achieved in studies using group sizes within this range. Diabetes SMAs (the largest evidence base with ~47 studies) typically enrolled 10–15 patients per session and demonstrated HbA1c reductions of 0.27–0.55%.

Individual primary care visits average approximately 18–23 minutes, so a 4-hour clinic session accommodates 12 patients. For an SMA to be revenue-neutral, attendance must be sufficient to offset the clinician time displaced from individual visits. Because no-show rates in primary care average 15–23% overall and approach 27–34% in populations with unmet social needs, SMA panels must be over-recruited to reliably meet the break-even census. Clinical sites will need to account for attrition and no shows. If the group does not have enough patients it will risk making SMAs financially unsustainable. Currently, many SMAs overenroll to account for patients who do not attend. Since SMAs can schedule more than one patient at a time, this helps reduce no-shows and increase access. SMAs are not cost-effective compared to individual appointments if enrollment is below a certain number.

The literature describes GMVs ranging from 12 to 20 patients, but billing compliance and clinical quality considerations favor an upper limit of approximately 20. Since billing must reflect only individualized provider time with each patient (not group time), larger groups reduce the per-patient individual time available. Beyond 15 patients, individual time becomes compressed to a point where meaningful medical decision-making may be compromised, increasing both clinical and billing compliance risk.

The SMA model is distinct from group education or support groups because it includes all components of an individual clinical encounter — vitals, patient interview, physical examination, medical management (medication review, ordering laboratories and referrals) — delivered within a group context. The 15 range allows sufficient group diversity for peer learning and support while preserving adequate individual clinician-patient time for personalized medical care.

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CMS Comment 4: Timely Accessibility; SMA for the Right Patient by the Right Clinician delivering the right medical care.

Recommendation: Preserve continuity of care without restricting timely access to SMAs. The proposed guidance would limit SMAs to "beneficiaries who have received a professional service from the billing physician of the exact same specialty and subspecialty, belonging to the same group practice, within the previous 12 months." We respectfully recommend two modifications.

1. Remove the prior-relationship lookback requirement when the SMA is medically necessary such as a patient with diabetes who requires a diabetes SMA.

Conditioning SMA eligibility on a documented prior encounter with the same billing clinician introduces avoidable delay for patients who need care now. A patient newly identified with prediabetes, uncontrolled hypertension, or a positive fall-risk screen should be able to enter the appropriate SMA at the point the need is identified, rather than waiting to establish a qualifying prior service. Medical necessity, not the timing of a preceding visit, should determine access.

2. Define the qualifying relationship at the level of the health system, not the individual specialty, subspecialty, or group practice.

We recommend that eligibility be extended to patients who receive care within the same health system or organized delivery network, rather than restricted to a "billing physician of the exact same specialty and subspecialty within the same group practice". Not all clinical groups provide all types of SMA that are medically necessary for individual beneficiaries. Within the primary care providers scope of practice, making a referral to a provider with a unique scope of practice such as the dietitian or licensed social worker in their health care system is standard of care. To have parity, a primary care provider should be able to recommend a SMA that is medically necessary within their health system. SMAs are delivered across a broad range of services and by a broad range of qualified clinicians, for example:

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A physician and physical therapist provide a SMA for cognitive decline and fall prevention

An endocrinologist-led diabetes SMAs embedded in primary care clinic

A prenatal SMAs delivered by midwives and obstetrician-gynecologists in primary care clinic

Under the proposed language, a patient followed in primary care could be excluded from an endocrinology-led diabetes SMA in the same building, and a patient could be excluded from group prenatal care delivered by a different practice within the same system. These are precisely the arrangements that make SMAs operationally viable.

CMS Comment 5: Required Components for Each SMA Session

We recommend that SMAs provide high-quality care and reflect the scope of practice of a clinician combining patient education, evidence-based skill building for self-management, lifestyle recommendations, behavior change support, and appropriate clinical medical treatment and management.

One goal of the SMA is to allow the clinician to deliver the full range of their scope of practice and high quality medical care. Therefore, different services might be provided including a history, physical exam, ordering laboratories and imaging, patient medical device skills (e.g.,inhalers, glucose monitors, medication boxes), comprehensive medication review, screenings (e.g, cognitive, fall risk, hearing and vision, depression, social determinants of health, nutrition, exercise, activities of daily living). For example, for patients who have cognitive decline and frequent falls, should be recommended a SMA that prioritizes — balance and functional exercise, medication review/deprescribing, and screening for home hazard modification.

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We strongly agree that SMAs integrate group education, counseling, and peer support with individualized patient clinical assessment and medical care. It will be important not to limit what makes the SMA a valuable delivery model in patient care. The SMA provides an opportunity for patients to master skills to manage their health conditions. For example, a diabetes SMA might include the hands-on instruction on use of insulin pumps and self-glucose monitors, how to perform a self-foot exam, practicing appropriate, safe exercise to avoid falls and low blood sugars, and how to cook a low- glycemic-index diet. An SMA reflects the needs of the patients at many levels of care and may need to adapt its content and medical care depending on the context of the SMA. For example, during Covid, many SMAs were delivered online.

Another productive SMA is to provide physical exams and primary care such as information on screenings, fall risk prevention, and vaccinations. For example, Dr Geller has been providing primary care such as Medicare Wellness exams, pediatric physical exams, and osteoporosis / risk of fall prevention SMAs.

CMS Comment 6: Guardrails in Preventing Fraud, Waste, and Abuse

We agree that it is critical to reduce fraud, waste, and abuse in SMA. If this occurs, it will undermine the financial and cost savings for this model of care. We agree that fidelity to the SMA model is critical to maintaining its integrity and delivering high-quality health care. Routine audits of clinical documentation and review of appropriateness of coding are important. Among existing healthcare SMA programs in the United States, the presence of a medical system-wide SMA Executive Committee for oversight has been helpful in sustaining and overseeing compliance.

Documentation and Compliance Guardrails

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Individualized documentation requirements: Each patient's medical record must contain a distinct, patient-specific note reflecting the specific E/M services, clinical assessment, and care plan modifications that patient received.

Attendance verification: There are existing SMAs that require a patient to sign a required sign-in sheet(in-person) or timestamped login/logout records (telehealth) for every session, cross-referenced with billed claims. For telehealth SMAs, require active video participation rather than audio-only.

Audit and Monitoring

Routine claims audits: Regular audits comparing the number of patients billed per session against attendance records and clinical documentation to ensure appropriateness of coding and commensurate billing

EM codes - Adhere to existing billing guidelines and regulations so they follow the same oversight.

Structural Safeguards

Consent documentation: Requiring documented patient consent for both SMA participation and confidentiality terms creates an auditable paper trail confirming voluntary participation.

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Staff training requirements: Requiring billing providers and staff to complete initial and continuing education on SMA-specific billing rules, administrative needs, and workflows. Competencies for clinical and administrative training for SMAs needs to be determined in addition to providing widespread buy in from upper leadership of medical systems for the model to be successful

CMS Comment 7 Proposed RVU Valuation May Undervalue or Overvalue the Service

The proposed valuation is based on CPT 99213 plus CPT 96202. Many SMA participants require moderate-complexity medical decision making comparable to 99214 encounters. A fixed valuation of 1.73 work RVUs may undercompensate providers caring for medically complex patients and may not adequately recognize planning, coordination, and documentation burdens.

Additionally, we recommend allowing clinicians to add on the G2211 code when appropriate to the GSMA code. This code reflects the medical visit complexity of patients associated with evaluation and management (E/M) services who attend the SMAs. G2211 recognizes that patients may need additional resources when a clinician provides longitudinal care for patients with serious or complex conditions in an SMA

We acknowledge that it is critical to set the reimbursement for a SMA that matches the medical care provided with proper reimbursement. Currently, for 99213, which is the most common E&M codes employed to bill for SMAs, the proposal by CMS is significantly lower than the (99213+ G2211) E&M codes which high quality SMAs with multiple health conditions use. In general, given the effective outcomes for many chronic conditions with SMAs, the proposed CMS model should match the reimbursement used for a traditional (99213+ G2211) one-on-one visit because, typically in an SMA, multiple chronic conditions (for example, obesity, type 2 diabetes, hypertension, hyperlipidemia, etc.) are all therapeutically benefited simultaneously.

Given that a traditional individual follow-up visit, where >=2-3 chronic problems are addressed, would be billed 99214 (+G2211), therefore, SMAs deserve the same reimbursement (even

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though SMAs are clearly superior in terms of therapeutic outcomes, with not just stronger adherence to lifestyle therapy, but also

Finally, SMAs are led by clinicians from many disciplines. Physicians, pharmacists, dietitians, behavioral health specialists, nurses, and other clinicians frequently provide distinct services. CMS should permit separate billing for separately documented services provided by different professionals.

CMS Comment 8 FQHC and RHC Considerations

CMS should explicitly include FQHCs and RHCs. These organizations serve medically underserved populations with significant chronic disease burdens and may benefit substantially from SMA implementation.

Conclusion

SMAs are individualized medical care delivered within a group setting rather than educational classes. CMS should preserve flexibility around conditions, duration, group size, multidisciplinary participation, and reimbursement to maintain the effectiveness of this evidence-based model.

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