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February 24, 2021

The Honorable Joseph R. Biden, Jr.  
President  
The White House  
Office of President  
1600 Pennsylvania Ave NW  
Washington, DC 20500

The Honorable Kamala Harris  
Vice President  
The White House  
Office of the Vice President  
1600 Pennsylvania Avenue NW  
Washington, DC 20500

Dear President Biden and Vice President Harris:

The Society of General Internal Medicine (SGIM) thanks you for the commitment your administration has already demonstrated to protecting patients and communities, particularly as our country continues to struggle to contain COVID-19, which has had a disproportionate impact on vulnerable populations in the U.S.

SGIM is a member-based medical association of more than 3,000 of the world's leading academic general internists, who are dedicated to improving the access to care for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to delivering high quality care and ensuring patients have access to a well-trained physician workforce.

We applaud the commitment your administration has demonstrated to addressing health inequities and social determinants of health, most notably the establishment of the COVID-19 Health Equity Task Force and the American Rescue Plan provisions to address the health inequities exacerbated by the COVID-19 pandemic. SGIM welcomes the opportunity to work with you to address these issues both as they relate to the pandemic and the health care system generally. These challenges are longstanding and must be addressed to reach our shared goal of improving the health of all Americans.

We are writing to urge you to consider the following policy recommendations that focus on three priority areas—research, clinical practice, and educating the next generation of physicians. All of which we believe will help achieve better health in this country.

## RESEARCH RECOMMENDATIONS

As you both know, your announcement of your health and science team has demonstrated clearly that your comments during the campaign about the critical role of science in your administration is real and it is strong. The elevation of Dr. Eric Lander to the Cabinet in his capacity as the Director of the Office of Science and Technology Policy (OSTP) and Presidential Science Advisor is a wonderful innovation that at long last will give science a critical seat at a very important table.



More directly in the area of health research, SGIM members are national and international leaders in health services and primary care research. This leadership informs many of our key policy and funding priorities which we offer here for your consideration.

***Support the Agency for Healthcare Research and Quality (AHRQ)***

With proper leadership and support from the White House, AHRQ can play a critical role in the future shape of healthcare in America. There are multiple areas in need of research that only AHRQ addresses. Among those important issues are:

Patient Safety – AHRQ is the lead federal agency dealing with patient safety in an evidence-based, scientifically valid manner. The Agency leads research and implementation projects that bridge the gap between basic and clinical research and the actual provision of health care to patients. In addition, AHRQ develops research-based tools to enable clinicians to know what to do and how to do it to make care safer for the American people.

AHRQ's patient safety portfolio includes the following:

- Patient Safety Research Program;
- Hospital Acquired Infection Program;
- Patient Safety Organizations Program;
- National Health Quality and Disparities Program; and
- Consumer Assessment of Health Care Providers and Systems Program.

Health Services and Primary Care Research – As important as the patient safety portfolio is, AHRQ also conducts research in many other areas, such as the broad field of health services research, the under-valued field of primary care research, and the growing priority it has placed on digital data.

The important role that AHRQ plays in health services research and primary care research is only limited by its long-term lack of financial resources. **While the United States currently spends over \$4.0 trillion on health care, AHRQ's budget to keep patients safe and to improve quality throughout primary care is less than \$450 million (0.01125% of the total spend on health care). Addressing this misallocation of resources can have a significant positive impact for the American people and their physicians.**

***Support for the National Institutes of Health (NIH)***

SGIM joins with the entire health care research advocacy community in respectfully requesting that the administration make the support of the broad base of biomedical research conducted at the NIH among its highest priorities moving forward. The COVID-19 pandemic has demonstrated the importance of a long-term, robust and sustained investment in basic, clinical, and the full range of translational research. For the last four years, the community's starting point has been to overcome drastic recommended reductions in NIH funding. We feel confident that those days are in the past and your administration understands the issue very well and will be our partners in making the most of this important resource.



**SGIM and our colleagues interested in health care research have joined together to support the implementation of a formula approach to setting NIH funding at a level of the rate of increase in the Biomedical Research and Development Price Index (currently 2.4 percent) plus 5.0 percent real growth. For FY22, this rate of increase would set NIH funding at \$46.111 billion, or a \$3.177 billion increase.** Maintaining that level of growth throughout the administration's term in office will go a long way toward building the kind of research infrastructure that will enable scientists to address chronic and acute disorders and build a healthier future both domestically and globally. We also know that, for example, the success of science in creating vaccines for SARS-CoV-2 in record time happened because of years of research on coronaviruses that has been conducted at universities, research institutes and at the NIH itself.

For all this success, however, an important issue has gone unaddressed throughout 2020. When the pandemic began to spread and universities and their laboratories were ordered closed in mid-March, literally billions of dollars of on-going research was lost. The inability of researchers to be present to continue basic and clinical research experiments led to projects being cancelled and years of work wasted. More directly, SGIM members suffered significant disruption of patient-centered research, as patients were unable to participate during a period of lockdowns mandated by civil and university officials.

**Restarting postponed research, according to congressional testimony given by NIH Director, Dr. Francis Collins in September, will likely cost over \$10 billion. At the same time, it will be critical for the administration to support the research pipeline and address the impact on young investigators who may need more time added to training grants and fellowships, as the bottom has fallen out of the job market for this next generation of scientific research leaders.**

#### ***Health Equity and Social Determinants of Health***

Among the most critical areas for research throughout HHS – NIH, AHRQ, the Center for Medicare & Medicaid Innovation, and other agencies – are health equity and addressing the social determinants of health, shared interests of your administration and SGIM members.

It is critically important that the Department and the administration more broadly maintain a steady and unwavering focus on health equity. **We strongly support special programs to increase equitable access to all levels of health services and primary care, and to specifically address social determinants of health, which can advance equity. The key to proper implementation, however, is to support both financially and in policy the research related to advancing health equity and specific programs to increase diversity in the health professions.**

#### **CLINICAL PRACTICE RECOMMENDATIONS**

Our members practice across the country in both urban and rural areas and witness firsthand the inequities in the health care system. We urge you to address these issues, which have been long ignored to improve the health of all Americans.



### ***Eliminate Medicaid Requirements that Limit Access***

SGIM members include health services researchers, front-line primary care, safety-net physicians, and hospitalists who study and serve Medicaid populations. Our clinicians are intimately aware of the negative effects on patients of losing Medicaid coverage, and our researchers have demonstrated the clear harms of Medicaid work requirements and the resulting loss of coverage, harms to health, and lack of increase in employment.<sup>i ii</sup>

**We appreciate the steps your administration has already taken to eliminate the Medicaid work requirements and urge you to employ all methods available to ensure the section 1115 waivers authorizing work requirements will no longer limit access for those who would otherwise be eligible for Medicaid. Similarly, we encourage you to end the Healthy Adult Opportunities program that would allow state block grants to reduce overall Medicaid funding, enrollment and benefits. SGIM welcomes the opportunity to work with your administration to end policies limiting Medicaid eligibility and support the development of new policies to increase Medicaid coverage during this unprecedented time of crisis, where vulnerable Americans are losing employer-sponsored insurance and when the safety net is needed more than ever.**

### ***Support Primary Care and Equity in Value-Based Care***

The Medicare Access and CHIP Reauthorization Act (MACRA) (P.L. 114-10) authorized the Quality Payment Program (QPP) to shift Medicare from paying for volume to paying for value. This builds upon the efforts to consider social factors and equity in the value-based care authorized by the Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185) (IMPACT, 2014). However, the QPP, and specifically its Merit Based Incentive Payment System (MIPS), has not adequately considered equity. Safety net and rural practices fare worse in the program.<sup>iii iv</sup> Social determinants of health, including the ability to afford healthy food and medications, transportation, time-off from work and childcare to attend health care appointments, and housing security, play a substantial role in these discrepancies.

The problems with these policies are not new and stem from the legacy programs on which they were modeled—the Physician Quality Reporting System, the Electronic Health Record (EHR) Incentive Program, and the value-based modifier—which demonstrated similar issues. Prior to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), however, the financial implications to these practices caring for vulnerable patients was minimal. Now the increasing magnitude of payment modifications required by the QPP means that substantial Medicare dollars are being redistributed away from safety net practices caring for vulnerable populations and to large, urban health care systems – a “reverse Robin Hood” effect.

These structural inequities have been part of the healthcare system for decades and cannot be allowed to persist moving forward. **SGIM welcomes the opportunity to work with the incoming administration and Centers for Medicare & Medicaid Services (CMS) leadership to address these issues.** SGIM is preparing a white paper on equity in value-based care, which we will share with your health care team upon publication.



Addressing these inequities alone, however, will not be sufficient. **Your administration must also invest in a strong primary care system.** SGIM has joined with six other organizations to [call](#) for a greater investment in primary care as a public good and place this country's primary care system on par with high performing countries to improve health outcomes. This along with increased equity in value-based care systems will ensure those who are most vulnerable are receiving the care they require.

#### ***Support Patient Access to Care by Appropriately Valuing Non-Procedural Services***

CMS recently finalized the first significant payment improvements for outpatient evaluation and management (E/M) services beginning with the calendar year (CY) 2021 Medicare Physician Fee Schedule (MPFS) since the implementation of the Resource-based Relative Value Scale (RBRVS) in 1992. The longstanding underpricing of cognitive physician services within the MPFS has led to a skewed workforce and has impaired access, not just to primary care services, but also to a full range of medical specialty services that are important to all patients. The changes being implemented in 2021 are an important first step to ensuring that the definitions and valuations of all E/M services are accurate and reliable.

However, more must be done to ensure the MPFS is a reliable resource for developing the future of health care delivery. The principal architect of the RBRVS, Dr. William Hsiao from Harvard University, clearly stated that the development of the E/M portion of the MPFS was not adequately supported and that more refinement was needed from the very start of the RBRVS three decades ago. SGIM believes the existing E/M code families, outpatient as well as inpatient, do not accurately describe the non-procedural work delivered to patients. **While we are appreciative of the recent changes finalized by CMS, we believe that the agency must continue this important work and address the accuracy of E/M service code families, most notably the inpatient E/M family, as well as taking a closer look at the work required to deliver comprehensive E/M care for those patients with multiple chronic conditions.**

**SGIM, as a member of the Cognitive Care Alliance, has recommended that CMS establish an expert panel to examine this issue. We envision the panel will be charged with developing an evidence-based approach to assess how the current E/M service codes are defined and valued within the RBRVS paradigm and whether documentation expectations can be developed to ensure effective communication and reduce clinician burden.** Moreover, the expert panel would help to identify gaps in data and inadequacies in the processes CMS currently employs. If warranted, the expert panel may propose solutions and recommend changes that may be made to the E/M code set to ensure the valuations of these codes reflect current medical practice. Should the panel be successful, we believe CMS will be armed with the necessary data and information to describe non-procedural work that is part of ongoing evaluation and management. We urge your administration to continue this important work to appropriately define and value non-procedural care.

#### **EDUCATION AND WORKFORCE RECOMMENDATIONS**

##### ***Reforming the Medicare Graduate Medical Education Program***



The Medicare graduate medical education (GME) program is central to the development of a robust, well-trained workforce. SGIM recommends the administration reform the GME program to ensure there is a robust and sustainable physician workforce that can provide high quality, high value, and patient-centered care. Our [white paper](#) outlines five primary recommendations for GME reform that we continue to believe will provide viable options to ensure patient access to care while also addressing the nation's physician workforce needs:

- **Distribution of Physician Specialties:** The GME system should provide incentives to institutions and training programs to align the practice patterns of their graduates with national and regional workforce needs.
- **Funding Mechanisms:** All entities that pay for health care should contribute to GME funding, which should reflect the true cost of training a physician workforce aligned to the nation's health care needs.
- **Transparency:** GME dollars must be spent transparently and exclusively for resident training and related costs.
- **Competency-based Curriculum Accountability:** GME-funded residency training programs must demonstrate that their graduates have the competencies necessary to practice 21st Century medicine.
- **Education Innovations:** Funding must be available for GME innovations designed to positively impact the health care workforce and the federal government should support and test innovative education and training models to prepare the next generation of physicians.

**To ensure high-quality patient care, we respectfully request you consider our recommendations for GME reform.** The current GME program does not support the delivery of our nation's complex, ever-changing health care system. Therefore, we recommend these changes which will better prepare the next generation of physicians and strengthen patient access to care.

#### ***Impact of COVID-19 on Residents and all Trainees***

The COVID-19 pandemic has had an unprecedented impact on residents and medical students. While on the front lines of the crisis, teaching physicians and medical residents have experienced significant challenges in maintaining educational quality while balancing the risk of transmission. This has been particularly challenging, for those with underlying health conditions who have had to turn down training opportunities, and those whose training was interrupted as a result of the pandemic. SGIM supports all efforts to protect residents' clinical education during the COVID-19 pandemic and mitigate the physical and psychological burdens that are associated with this crisis. **Specifically, primary care physicians and hospitalists, including medical residents and trainees, should receive financial support, such as loan forgiveness, for the unprecedented risks they are taking on the front lines of the COVID-19 pandemic.** Providing meaningful financial relief to providers on the front lines will ensure a robust primary care workforce for the future.



### ***Preserving and Strengthening Medical Education at the Veterans Health Administration (VA)***

As the largest provider of medical training in the nation, the VA provides training for over 40,000 individual physician residents annually and serves more than 9 million veterans each year. Authorized as part of the VA MISSION Act of 2018, the VA has recently launched the Veterans Community Care Program (VCCP) to replace the Veterans Choice Program and allow veterans to receive hospital care, medical services, and extended care services through non-VA, community health care entities or providers. While SGIM appreciates the VA's effort to expand veterans' access to care, we must ensure that any changes made do not compromise the quality of care provided to veterans. SGIM strongly believes that veterans are best served by those who specialize in delivering care to this population, and any investment in veterans' health care should focus on expanding access to these services the VA currently excels in providing.

As the VCCP expands, SGIM remains concerned it may also undermine efforts by VA facilities to train future providers to care for our country's veterans. Any changes to the delivery of veterans' health care must not compromise the important role of medical education at the VA as their trainees are almost twice as likely to stay and work for the VA after completing their training. **We urge your administration to preserve the VA's important training function to ensure a robust next generation of physicians to care for the unique needs of our country's veterans.**

On September 22, 2020, President Trump issued an Executive Order (EO) on "Combating Race and Sex Stereotyping," which has serious implications for VA medical training, specifically for teaching and research related to racism and disparities in medicine. The EO restricts federal agency training on racial sensitivity and diversity and enforces penalties for agencies that do not comply with the EO. As a result, VA training hospitals in the U.S. have cancelled diversity training programs, and there are significant penalties for agencies that don't comply with the EO. The EO has potential to affect any institution that receives federal funding, and thus could have an adverse effect on diversity training in all academic institutions. **As you have already committed to addressing racial equity, SGIM urges you to preserve anti-racism curricula in academic medicine and create a more equitable health care system in this country.**

### ***Protecting International Medical Students***

International medical graduates (IMGs) are essential to our nation's health care workforce and biomedical research enterprise. **SGIM continues to recommend that policies from the US Department of State regarding routine visa services, specifically routine visa processing for medical residents and physicians, ensure that IMG physicians and students with J-1, H-1B, and O-1 visas remain exempt from all immigration bans or suspensions in services.** This will ultimately ensure that we have a robust health care workforce to respond to the COVID-19 pandemic and future pandemics.

J-1, H-1B, and O-1 visas are often used by medical residents, physicians, postdoctoral researchers, and graduate students who work and train in the U.S. These visas make it possible for non-citizen physicians to provide essential health care services in our communities without which our existing health care provider shortages would be even worse. These non-citizen physicians are essential to the U.S. health care system as they are currently serving on the front



lines of the COVID-19 pandemic in underserved communities. Furthermore, these visas allow international students to study and conduct research in the U.S; these students often remain here and contribute their skills to research to promote and improve better health outcomes for people around the world.

Thank you for the opportunity to share our expertise on these important issues. We welcome the opportunity to meet with you and your administration to discuss these issues further. Please direct any questions and correspondence to Erika Miller of CRD Associates at [emiller@dc-crd.com](mailto:emiller@dc-crd.com) or (202) 484-1100.

Sincerely,

A handwritten signature in black ink that reads "Jean S. Kutner". The signature is written in a cursive, flowing style.

Jean S. Kutner, MD, MSPH  
President, Society of General Internal Medicine

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<sup>i</sup> Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements - Results from the First Year in Arkansas. *N Engl J Med*. 2019 Sep 12;381(11):1073-1082. doi: 10.1056/NEJMs1901772. Epub 2019 Jun 19. PMID: 31216419.

<sup>ii</sup> Sommers BD, Chen L, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Aff (Millwood)*. 2020 Sep;39(9):1522-1530. doi: 10.1377/hlthaff.2020.00538. PMID: 32897784; PMCID: PMC7497731.

<sup>iii</sup> Johnston KJ et al.. Clinicians With High Socially At-Risk Caseloads Received Reduced Merit-Based Incentive Payment System Scores. *Health Aff (Millwood)*. 2020 Sep;39(9):1504-1512.

<sup>iv</sup> Khullar D et al.. Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. *JAMA*. 2020 Sep 8;324(10):975-983.