

### Welcome to the Health Policy Theme Issue

This month's *Forum* covers a variety of topics related to health policy: Medicaid expansion, a personal account of one physician's Hill Day experience, potential changes to graduate medication, and tips on becoming a "60-second" advocate. I would like to thank Francine Jetton, Director of Communications at SGIM, for her efforts organizing the content for this issue.

—Karen R. Horowitz, MD  
Editor, SGIM *Forum*

## COMMENTARY

### Advocacy for Medicaid Expansion— Tale of Two Americas

Mark D. Schwartz, MD

*Dr. Schwartz is professor of population health at the NYU School of Medicine and chair of the SGIM Health Policy Committee.*

#### CONTENTS

1. Commentary . . . . .	1
2. Essay . . . . .	2
3. President's Column . . . . .	3
4. From the Society: Part I . . . . .	4
5. From the Editor . . . . .	5
6. Educators' Corner . . . . .	6
7. Sign of the Times . . . . .	7
8. From the Society: Part II . . . . .	8
9. New Perspectives . . . . .	9
10. Humanism in Medicine . . . . .	10

The triple aim of the Affordable Care Act (ACA) is to improve health, care, and cost in the United States. Expanding access to health care through public and private insurance reform is one of the pillars supporting these aims, and Medicaid policy is a major lever in expanding access to care.

The ACA leveled a very uneven playing field by requiring all states to expand their Medicaid programs and mandating coverage of adults with an annual family income up to 133% of federal poverty level (FPL) in 2014. Before the ACA, the threshold for Medicaid eligibility averaged 72% of FPL for all states but ranged from 11% (LA, AL) to 200% (MN, WI, ME, DC). States (mainly "Blue") that opted into Medicaid expansion early will receive 100% of the cost for newly eligible beneficiaries, thus maximizing their share of federal funds available for this expanded coverage. This federal support drops to 95% in 2017 and 90% after 2019. It is a very good deal for states.

The ACA was designed to provide Medicaid coverage to almost 17 million uninsured Americans. By expanding coverage to childless adults and setting national eligibility standards, the ACA aimed to end the historical distinction between the deserving and non-deserving poor that dates back to the Elizabethan era. Earlier this year, the US Supreme Court ruled, however, that mandating Medicaid expansion was unconstitutional. It was seen as coercive since states had to accept the new policy in order to maintain their federal Medicaid funding.

As of January 2015, 27 states plus Washington, DC, have opted into Medicaid expansion; 23 states (mainly "Red") have not yet expanded, but four of these are considering it (IN, TN, UT, WY). These states are delaying this policy decision for three core reasons: 1) political opposition to the ACA; 2) refusal to expand a perceived failed social

continued on page 11

# Reflection on SGIM Hill Day

George Weyer, MD

*Dr. Weyer is assistant professor of medicine and associate medical director for population management in the Primary Care Group at the University of Chicago.*

**SOCIETY OF GENERAL INTERNAL MEDICINE**

**OFFICERS**

**President**

**Marshall Chin, MD, MPH** Chicago, IL  
mchin@medicine.bsd.uchicago.edu 773-702-4769

**President-Elect**

**Eileen E. Reynolds, MD** Boston, MA  
ereynold@bidmc.harvard.edu 617-632-8270

**Immediate Past-President**

**William P. Moran, MD** Charleston, SC  
moranw@musc.edu (843) 792-5386

**Treasurer**

**Martha Gerrity, MD, MPH, PhD** Portland, OR  
gerritym@ohsu.edu (503) 220-8262

**Treasurer-Elect**

**David C. Dugdale, MD** Seattle, WA  
dugdaled@uw.edu 206-543-3547

**Secretary**

**Said A. Ibrahim, MD, MPH** Philadelphia, PA  
said.ibrahim2@va.gov (215) 823-5800

**COUNCIL**

**Eva Aagaard, MD** Aurora, CO  
eva.aagaard@ucdenver.edu (303)-724-5866

**David W. Baker, MD, MPH** Chicago, IL  
dbaker1@nmff.org (312) 503-6407

**Jada C. Bussey-Jones, MD** Atlanta, GA  
jcbusse@emory.edu (404)-778-1614

**Hollis Day, MD, MS** Pittsburgh, PA  
dayh@upmc.edu (412) 692-4888

**Ethan A. Halm, MD, MPH** Dallas, TX  
ethan.halm@utsouthwestern.edu (214) 648-2841

**Marilyn M. Schapira, MD, MPH** Philadelphia, PA  
mschap@upenn.edu (215) 898-2022

**Health Policy Consultant**

**Lyle Dennis** Washington, DC  
ldennis@dc-crd.com

**Executive Director**

**David Karlson, PhD** 1500 King St., Suite 303  
Alexandria, VA 22314  
karlsond@sgim.org (800) 822-3060; (202) 887-5150, 887-5405 Fax

**Director of Communications and Publications**

**Francine Jetton, MA** Alexandria, VA  
jettonf@sgim.org (202) 887-5150

I would be the first to admit that lobbying in Washington, DC, as part of this year's Society of General Internal Medicine (SGIM) Hill Day was not something I had expected to be doing this March. Coming of age in an era of entrenched political dysfunction and economic instability had given me a healthy sense of skepticism regarding the benefits of political engagement. However, by the time I was watching the Capitol building recede from view on my return flight, I had realized that direct political engagement is a natural and essential part of my role as a primary care physician.

My transition toward this sort of direct political engagement started after joining the general medicine faculty at the University of Chicago. I have had the privilege of becoming deeply involved in efforts to reshape our care model in response to a shifting reimbursement environment. We at the University of Chicago, like others across the country, are grappling with increased financial risk sharing and developing strategies to manage health outcomes within attributed populations. This work has made it

abundantly clear that decisions made in Washington have significant impact on the health resources available to my patients. Unfortunately, it has also become clear that physicians do not advocate with one voice and that opposing factions of organized medicine are as much a barrier to reform as the political log jams in Washington.

At the suggestion of my section chief, Deborah Burnet, MD, I applied for and received funding from SGIM to participate in this year's SGIM Hill Day as part of the "Chief's Challenge." I was grateful for the opportunity to try a new approach and, given SGIM's focus on academic primary care, research, and education, found the advocacy positions to be refreshingly aligned with my own values.

Even before arriving in Washington, it was apparent that SGIM's Health Policy Committee was organized and mission driven. I had been receiving weekly e-mails with logistical updates and background reading. For first-time attendees like me, there were helpful introductory sessions organized by Cara Litvin, MD, that included a presentation by the Patient-Centered Outcomes Research Institute (PCORI) director Joe V. Selby, MD. Cavarocchi-Ruscio-Dennis (CRD) Associates, SGIM's advocacy firm, had secured interviews with legislative aides from the home districts of all 70-odd attendees. We also were armed with "leave behind" materials and briefed by SGIM health policy aficionados including Mark Schwartz, MD, and Gary Rosenthal, MD, who updated us on the current efforts to avoid yet another patch for the flawed sustainable growth rate (SGR) and SGIM's position on graduate medical education (GME) reform.

continued on page 12

**EX OFFICIO COUNCIL MEMBERS**

**Chair of the Board of Regional Leaders**

**Daniel G. Tobin, MD, FACP** Waterbury, CT  
daniel.tobin@yale.edu (203) 568-6348

**ACLMGIM President**

**Jean S. Kutner, MD, MSPH** Denver, CO  
jean.kutner@ucdenver.edu (303) 724-2242

**Co-Editors, Journal of General Internal Medicine**

**Mitchell D. Feldman, MD, MPhil** San Francisco, CA  
mfeldman@medicine.ucsf.edu (415) 476-8587

**Richard Kravitz, MD, MSPH** Sacramento, CA  
rkravitz@ucdavis.edu (916) 734-1248

**Editor, SGIM Forum**

**Karen R. Horowitz, MD** Cleveland, OH  
Editor.SGIMforum@gmail.com (440) 562-0254

**Associate Member Representative**

**Brita Roy, MD, MPH** Birmingham, AL  
britaroy@uab.edu (248) 506-1511

## Where SGIM's Been and Where We're Going: Please Contribute to Our Strategic Planning

Marshall H. Chin, MD, MPH

[Population health] requires of us new teaching methods and new research approaches and broadens the scope of what it means to be a physician.



It is a great honor and privilege for me to serve as SGIM president and write my first *Forum* column. I would like to review where SGIM has been recently and encourage you to help us think about our future direction as an organization. As a voluntary member-run organization, SGIM has been engaged in incredibly diverse clinical, education, research, and policy activities. We face significant threats and opportunities—both internal and external—as a result of the current political and economic environment. By June 2015, SGIM's committees will submit their plans and budget requests for the upcoming year to Council for review. Thus, it is time to create a strategic plan that enables us to establish priorities and ensure that key issues are addressed.

I would like to highlight several key activities and trends of SGIM over the past five to 10 years. We have tried to stay at the forefront of care delivery issues crucial for primary care and hospital medicine. Early on, we organized conferences to establish research and education agendas for the patient-centered medical home (PCMH), and the most recent annual meeting was on the theme of team-based care. We have an outstanding Health Policy Committee that has been extremely productive (as this issue of *Forum* demonstrates), and we have increased our advocacy impact through collaboration with other professional medical societies in areas of mutual interest. We have established multiple career development

opportunities for members, including the mentoring programs, the TEACH program for junior clinician-educators, and the Academic Hospitalist Academy. We have been fueling the pipeline to primary care with programs such as the "Proud to be GIM" campaign led by Ann Nattiger, which tells first- and second-year medical students about the rewards of a primary care career. We have maintained the "let a thousand flowers bloom" approach, tapping into the great creativity and energy of members, resulting in diverse high-quality workshops, abstracts, and sessions at the annual meeting and impactful activities led by our committees, task forces, and interest groups. We've engaged in modern forms of communication and networking as a society through implementation of GIM Connect and social media.

Despite these accomplishments, 2015 is a potentially dangerous time for SGIM. It remains an uphill battle to recruit students to enter primary care fields. We have to combat the stinging image of the general internist as a hamster on a treadmill churning out patients in an inefficient system. The Affordable Care Act has provided health insurance to millions of Americans, but the rapid shift from fee-for-service payment to value-based payment schemes and global payment arrangements, including accountable care organizations, capitation, and bundled payments, has created new uncertainties for primary care. Research funding remains tight,

### SGIM Forum

#### EDITOR IN CHIEF

Karen R. Horowitz, MD [editor.sgimforum@gmail.com](mailto:editor.sgimforum@gmail.com)

#### MANAGING EDITOR

Christina Slee, MPH [tinslee@me.com](mailto:tinslee@me.com)

#### EDITORIAL BOARD

Deepa Bhatnagar, MD	<a href="mailto:dbhatnag@tulane.edu">dbhatnag@tulane.edu</a>
Alfred P. Burger, MD	<a href="mailto:aburger.md@gmail.com">aburger.md@gmail.com</a>
Mobola Campbell, MD	<a href="mailto:mobolacampbell@gmail.com">mobolacampbell@gmail.com</a>
Amanda Clark, MD	<a href="mailto:amandavick@gmail.com">amandavick@gmail.com</a>
Michele Fang, MD	<a href="mailto:michele-fang@uiowa.edu">michele-fang@uiowa.edu</a>
Patricia Harris, MD, MPH	<a href="mailto:pharris@mednet.ucla.edu">pharris@mednet.ucla.edu</a>
Sam T. Ives, MD	<a href="mailto:Samuel.ives@hcmcd.org">Samuel.ives@hcmcd.org</a>
Francine Jetton, MA	<a href="mailto:jettonf@sgim.org">jettonf@sgim.org</a>
Danielle King, MD	<a href="mailto:starrynightinno@yahoo.com">starrynightinno@yahoo.com</a>
Armand Krikorian, MD	<a href="mailto:armand.krikorian@advocatehealth.com">armand.krikorian@advocatehealth.com</a>
Ben I. Mba, MD	<a href="mailto:benjamin_mba@rush.edu">benjamin_mba@rush.edu</a>
Clifford D. Packer, MD	<a href="mailto:cdpacker39@gmail.com">cdpacker39@gmail.com</a>
Tanu Pandey, MD, MPH	<a href="mailto:tanumd@gmail.com">tanumd@gmail.com</a>
Archana Radhakrishnan, MD	<a href="mailto:rkrishnana@yahoo.com">rkrishnana@yahoo.com</a>
Shadia Constantine, MD, MPH	<a href="mailto:sssantos@geisinger.edu">sssantos@geisinger.edu</a>
Heather Sateia, MD	<a href="mailto:hsateia1@jhmi.edu">hsateia1@jhmi.edu</a>
Leigh H. Simmons, MD	<a href="mailto:lhsimmons@partners.org">lhsimmons@partners.org</a>
Kevin R. Smith, MD	<a href="mailto:kevin.smith78@gmail.com">kevin.smith78@gmail.com</a>
Neeraj Tayal, MD	<a href="mailto:neeraj.tayal@osumc.edu">neeraj.tayal@osumc.edu</a>
Christopher J. Wong, MD	<a href="mailto:cjwong@u.washington.edu">cjwong@u.washington.edu</a>
Gopal Yadavalli, MD	<a href="mailto:gopal.yadavalli@bmc.org">gopal.yadavalli@bmc.org</a>

The *SGIM Forum* is a monthly publication of the Society of General Internal Medicine. The mission of The *SGIM Forum* is to inspire, inform and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The *SGIM Forum* template was created by Phuong Nguyen ([ptnnguyen@gmail.com](mailto:ptnnguyen@gmail.com)).

with agencies such as the Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Outcomes Research Institute (PCORI) under annual political siege. Graduate medical education funding may change, as powerful organizations such as the Institute of Medicine call for substantial reforms that would affect general internal medicine (GIM) and academic health centers.

Yet the flip side of threat is opportunity. Our greatest strength as a society is you—our members. Thanks to our members, some of the most innovative thinkers and implementation specialists in academic medicine today, SGIM continues to provide leadership targeted to improve our

continued on page 13

## What is the Role of SGIM's Health Policy Committee?

Francine Jetton, MA

*Ms. Jetton is Director of Communications at SGIM and can be reached at [jettonf@sgim.org](mailto:jettonf@sgim.org).*

SGIM advocacy promotes and supports policies that improve patient care, strengthen education and training, and promote research in general internal medicine (GIM). The Society does not advocate for issues that are divisive within the SGIM membership. To use limited resources most effectively, advocacy focuses on issues that are critical to GIM's future or that allow SGIM to offer a unique perspective. SGIM follows a specific annual advocacy agenda that is categorized by the core areas of our organization. Thus, the Health Policy Committee (HPC), chaired by Thomas O. Staiger, MD, is organized into four subcommittees: Education, Research, Clinical Practice, and Member Outreach.

The Education Subcommittee, chaired by Robert B. Baron, MD, MS, and co-chaired by Jeffrey R. Jaeger, MD, is dedicated to advocacy in three major areas: 1) pre-doctoral education, residency training, and faculty development in primary care medicine, including the overall governance and financing of the federal government's graduate medical education system; 2) diversity of the health professions; and 3) interdisciplinary and rural health professions education. These three areas are embodied in federal legislation that is included in the Title VII Health Professions legislation, commonly known as "Title VII", and the Medicare graduate medical education program. Anyone with an interest in or dedication to educating health professionals or promoting access for disadvantaged, underserved, and vulnerable populations would be welcome to join the Education Subcommittee. Their work addresses professionalism, human rights, health literacy, patient safety, quality improvement, recruiting a more diverse health professions workforce, and educating professionals to eliminate health disparities in the 21st century.

The Research Subcommittee, chaired by Gary E. Rosenthal, MD, and co-chaired by Nancy L. Keating, MD, MPH, generates policy recommendations and advocates for research support for the improvement of clinical care and health care delivery through clinical research and health services research. The subcommittee also advocates for education and training that supports such research. The primary focus is on supporting and providing input into research-related policies for the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and other federal agencies and private sector agencies, including the Patient-Centered Outcomes Research Institute (PCORI).

To further these goals, the Health Policy Research Subcommittee advocates via initiatives organized on behalf of SGIM to inform and influence Congressional action and implementation by administration. These actions include short- and long-term efforts to ensure the support of research and research training consonant with SGIM's objectives.

The Clinical Practice Subcommittee, chaired by Keith A. Vom Eigen, MD, PhD, MPH, and co-chaired by Thomas A. Sinsky, MD, monitors governmental activities that enhance or restrict patient access to health care and/or improve reimbursement and support for clinical practice. Specifically, with the support of CRD Associates, SGIM's lobbyists, subcommittee members track select Centers for Medicare and Medicaid Services (CMS) and Health and Human Services programs. Subcommittee members are encouraged to identify and collaborate with colleagues within SGIM and from other profession organizations, including the American College of Physicians and the American Academy of Family Physicians. Sub-

committee members are asked to become knowledgeable in one or more issues. Areas of subcommittee focus include the following:

- *Physician reimbursement.* This includes the activities of the Relative Value Scale Update Committee (RUC), CMS changes in the conversion factor (CF), Congressional changes in the sustainable growth factor (SGF), and the Medicare Payment Advisory Commission.
- *Medicare.* This includes the patient-centered medical home; pay for performance; and national quality initiatives, program qualifications, and conditions.
- *Health information technology (HIT).* This includes monitoring federal plans to support HIT deployment and maintenance.
- *Health care access.* This includes activities related to any federal regulations that might interfere with health care access, including health disparities and barriers to care based on language. This also includes rural health initiatives, community health initiatives, and the National Health Services Corps. The subcommittee is committed to universal health care access.

Finally, the Member Outreach Subcommittee, chaired by Cara B. Litvin, MD, MS, focuses on recruiting new members and encouraging the involvement of all HPC members. In the ideal world, every SGIM member is an advocate. In truth, advocacy can be daunting, time-consuming, and highly specialized. It takes a glossary just to know what all the acronyms mean.

Specific goals of the Membership Development Subcommittee are to expand the diversity of the member-

continued on page 5





## The Importance of Advocacy

Karen R. Horowitz, MD

This week, the US House of Representatives passed HR 2, a bill to reform Medicare payments to physicians and repeal the standard growth rate fix. Hopefully, by the time you read this, the Senate will approve the bill, and it will go to President Obama for his anticipated final signature. This would not have been possible without the strong advocates among us who have given voice to the perspective of physicians in our public discourse. I am proud of the public voice of SGIM members who, along with the American College of Physicians and other organizations, have lobbied hard for this initiative.

It is easy for us to become complacent and let others decide the political future of our profession. We retreat to our own agendas, mired in the tasks of patient care, research, teaching, and (oh, yeah!) the de-

mands of our personal lives. Over the past 15 years, we have seen a paradigm shift in our careers. We have opted out of "private practice." Some have profited from the sale of busy practices to health care systems. Others have just been driven out of business by economic pressures and the burdens on private practice as we knew it. It is impossible to estimate how many of us have made career choices in order to satisfy personal professional interests and how many were driven there by economic disparities and the burden of educational debt. As long as maintenance of certification (MOC) targeted only the recent graduate, there was little regulation of its growth and impact. It is only in the past year, when the American Board of Internal Medicine changed its approach to physicians formerly credentialed with lifelong

certification, that senior-level physicians (i.e. those who wield power in academic medicine) have banded together to confront the contentious beast that MOC has become.

These remarkable events are the tangible results of thoughtful debate that has played out over years of advocacy for our profession. This issue of *Forum* highlights the health policy initiatives of SGIM and the work of its members. Through these efforts, the SGIM Health Policy Committee works for each of us to strengthen our profession and broaden our opportunities. There is still much work to be done. If you are interested in participating in Health Policy Committee initiatives, contact Francine Jetton ([jettonf@sgim.org](mailto:jettonf@sgim.org)) or Tom Staiger, Health Policy Committee chair, ([staiger@u.washington.edu](mailto:staiger@u.washington.edu)) to learn more.

SGIM

## FROM THE SOCIETY: PART I

continued from page 4

ship, create educational tools to make advocacy more accessible, and keep information on the SGIM website current and relevant. The subcommittee also takes a key role in planning and conducting "Hill Day." During this structured educational event, usually held in mid-March, members are guided through a day of advocating for SGIM issues in their congressional representatives' offices in Washington, DC. The subcommittee also provides advocacy updates to the regional meetings, monthly articles for *SGIM Forum*, and health policy curriculum for the SGIM website.

For more information about joining any of these committees, please contact committee chair Thomas O. Staiger, MD, at [staiger@u.washington.edu](mailto:staiger@u.washington.edu).

SGIM



### KAISER PERMANENTE®

The Division of Research in Kaiser Permanente's Northern California region is accepting applications for its July 2016 class of Delivery Science post-doctoral fellows. The application deadline is **September 15, 2015** for fellows beginning **July 2016**

**Location:** Oakland, California

**Eligibility:** We seek outstanding candidates with health professional doctorate degrees and/or research doctorate degrees in related fields. Applicants must be eligible for US employment. Women and minority candidates are encouraged to apply.

**Program Goals for Delivery Science Fellows:** Enhancing skills to help highly-qualified researchers pursue successful research careers in delivery science; address critical health care delivery problems in priority areas and conduct research to help support advances in how medical care is delivered within the Kaiser Permanente integrated care setting and the U.S. health care system overall.

**Learning Opportunity:** Fellows will develop their delivery science research and writing skills for presentations and publications while being mentored by experienced scientists.

**Questions and Application:**

Email [DOR-Fellowship@kp.org](mailto:DOR-Fellowship@kp.org) or go to [www.dorfellowship.kaiser.org](http://www.dorfellowship.kaiser.org)

## GME in the Crosshairs

Domenic Ruscio

*Mr. Ruscio is a partner at Cavarocchi-Ruscio-Dennis Associates.*

Earlier this year, Society of General Internal Medicine (SGIM) President William P. Moran, MD, MS, sent the leadership of the House Energy and Commerce Health Subcommittee a series of recommendations for reforming Medicare's graduate medical education (GME) program. Those recommendations were in response to the panel's call for input on how best to improve the efficiency, effectiveness, and stability of the program—and just the latest sign that changes may be afoot for the \$10-billion-a-year program.

That GME is on the minds of policymakers is neither new nor surprising. Though it may be regarded as the gold standard for the world, from the time it was established in 1965 there have been calls to change this integral part of the physician training continuum. In the 1960s, concerns were voiced that the residency programs being subsidized operated too independently of one another. By the 1970s and 80s, policymakers were bemoaning the maldistribution of physicians by specialty type and geography, laying that problem squarely on GME's doorstep. In recent years, concerns surrounding medical errors, the integration of electronic health records, and coordination of care have prompted calls for a GME makeover because, according to the Medicare Payment Advisory Commission's 2009 report to Congress, the program is "not well aligned with objectives of delivery system reform."

While Medicare's GME program has perpetually carried a target on its back, the financial crisis of 2007 truly put the program in the crosshairs of the austerity movement.

In February 2010, President Obama issued an executive order creating the bipartisan National Commission on Fiscal Responsibility and Reform, a blue-ribbon panel charged with identifying ways to

right the nation's fiscal ship. What emerged was a series of bold reform proposals, many of which targeted big-ticket mandatory spending programs that collectively account for about two thirds of the federal budget. Prominent on the list, not surprisingly, was a proposal calling for a \$60 billion cut in Medicare GME payments over a decade.

Lacking the political will to take on politically charged mandatory programs like Medicare, the president and Congress instead struck a budget deal that put stringent limits on discretionary government spending. But it didn't take long before lawmakers realized that you can't get blood from a stone. Cutting discretionary spending, which accounts for a relatively small share of government spending, is simply not going to throw off enough savings to truly achieve fiscal stability. Instead, lawmakers have more recently begun to look seriously at other segments of the budget—most notably the governance and financing of GME.

Anticipating that Congress might opt for a meat-axe approach to GME reform—cutting funding while ignoring meaningful reform—SGIM undertook an in-depth examination of the system. What emerged were six recommendations that reflect the concerns of a society whose core interests include preparing a physician workforce capable of providing high-quality, high-value, population-based and patient-centered health care that is aligned with the changing needs of our nation's health care delivery system. Those recommendations are:

1. *Congress should fully fund the National Health Care Workforce Commission or similar entity.* Decisions affecting the allocation of GME positions must be based on data from

unbiased sources that assess current and future health care needs. However, there currently is no overall assessment of the specialty or geographic distribution of the US physician workforce. The non-partisan Commission is charged with developing recommendations for health care workforce policy, including data collection and analysis to assess current and projected workforce supply.

2. *All entities that pay for medical care should contribute to GME funding, and funding levels should reflect the true cost of training a physician workforce aligned with national needs.* Since all who receive and pay for medical care share the benefits of a well-trained physician workforce, all payers—not just the Centers for Medicare and Medicaid Services—should contribute to the cost of medical training. Furthermore, the decades-old formula for calculating direct and indirect medical education payments is long overdue for reassessment to bring it in line with the real costs of training physicians.
3. *In an era of scarce resources, GME dollars must be allocated transparently and exclusively for resident training and related costs.* The Health and Human Services secretary should immediately take steps to require institutions receiving GME funds to report their GME costs and the total amount of direct and indirect funds received, including the number of residents and fellows supported with GME funds by specialty and training location.
4. *GME-funded training programs must demonstrate that their graduates have the competencies*

continued on page 12

## Medicare's CCM Code 99490: Now we know, but what will we do?

John Goodson, MD, and Jeannine Engel, MD

*Dr. Goodson is associate professor of medicine at the Harvard Medical School, Massachusetts General Hospital, in Boston, MA, and Dr. Engel is associate professor of medicine at the University of Utah School of Medicine and physician advisor to Billing Compliance in Salt Lake City, UT.*

**W**ith the publication of the CY 2015 Physician Fee Schedule (PFS) Final Rule in November 2014, the Centers for Medicare and Medicaid Services (CMS) resolved much of the uncertainty surrounding the new chronic care management (CCM) service code 99490. The content stipulations remain daunting with workflow and patient-doctor relationship implications. Any Medicare patient with two or more chronic conditions would qualify for the CCM code—roughly 70% of all Medicare patients. Individual practices must now determine whether the payment is sufficient to cover the resources required to support the service expectations.

The CCM code is designed to pay for care management not adequately covered by the evaluation and management (E&M) codes (Table 1). The post-visit time expectation for the standard comprehensive outpatient E&M code 99214 is 10 minutes—an understatement of the usual communication and results management following a complex face-to-face interaction. In addition, there is no Medicare payment for telephonic and electronic care or night and weekend on-call coverage.

How was CCM changed with 2015 Final Rule?

With the Final Rule, CMS relaxed its position on several of the originally proposed CCM requirements:

1. CMS will not expect a higher level of electronic health record (EHR) support than what a practice has chosen to meet in previous year, either 2011 or 2014. In other words, there is no requirement for Meaningful Use Stage 2 (MU2) certification.
2. CCM provides a waiver of Medicare's traditional "incident to" requirements. Services can

be delivered by staff working with a practice but do not have to be delivered by employees of the practice per se. This will permit the development of standalone vendors that provide CCM services for a charge—likely a percentage of collections—or the centralization of CCM within enterprises. CMS has removed any concerns that CCM services can be delivered by facility-based practices.

3. Once the patient contract is signed, it will not have an expiration date. This could confuse Medicare beneficiaries who want to move away from a primary care practice but fail to cancel their contact. Presumably a CCM contract will automatically renew if a provider chooses to bill for post-discharge transitional care management (TCM) services after the 30 days of care, but CMS has not clearly stated this.
4. There are no added practice standards. Patient-centered medical home certification is not a precondition to CCM billing.
5. Interactive EHR data access must be available within a practice but not between practices. For example, if two cross-covering practices have different EHRs, both are allowed to bill for CCM coverage even though the systems are not interoperable. An electronic (not a fax) patient summary must be accessible to the cross-covering practice.
6. The CCM codes cannot be used by practices participating in the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration and the Comprehensive Primary Care (CPC) Initiative, with the exception of patients who are not otherwise attributed to a

participating practice. All others, including those in accountable care organizations, can.

CMS has been deliberately vague about several components of the CCM service code. This was done in response to criticisms received by the agency that the annual wellness visits and TCM codes had excessively detailed requirements.

1. The plan of care (POC) required must be developed by the doctor and the patient. CMS will provide some guidance, but there will be no nationwide convention.
2. The wording of the contract will be up to individual practices.
3. The documentation expectations are not clarified beyond the need for "an electronic footprint." CMS has not stated that a practice must submit time tallies, but the expectation is that there will be both documentation of care management and a total time attestation of 20 or more minutes of care management in the EHR each month. Documentation time itself will count. The time attestation could be as simple as a statement such as the following, "At least 20 minutes of combined staff time was allocated to the chronic care management of this patient this month," along with notations in the record of care management dated that month.
4. Billing can be submitted with just one diagnosis, but it would be most prudent to have at least two.

### Will CCM payment improve physician pay?

Payment for this code will be \$32.94 for facility (e.g. academic medical

continued on page 14

## Health Policy Curriculum Advisory Board to be Created at SGIM

Theodore Long, MD

*Dr. Long is a Robert Wood Johnson clinical scholar at the Yale School of Medicine in New Haven, CT.*

**A**s physicians, we see the effects of health policy in our practices every day. Whether it's access to care for Medicaid patients or availability of National Institutes of Health funds to pursue our research, we see the role health policy plays in our lives. However, the breadth and complexity of health policy is often daunting, making it difficult to engineer an educational strategy that will be broadly relevant. The SGIM Health Policy Committee has ascertained that members want to engage in health policy teaching and has formulated a plan to engage members.

In a survey conducted by the SGIM Health Policy Member Outreach Subcommittee, among SGIM residents, fellows, and medical students, 96% wanted more educational sessions about health policy (n=26). Respondents indicated that they wanted health policy sessions at SGIM conferences and online resources for active health policy issues as well as background information on core topics and a summary of SGIM priorities.

When attendings from the Health Policy Committee were surveyed (n=25), 71% reported that they wanted to better understand the Affordable Care Act, and 92% said they were interested in attending more educational sessions. They similarly prioritized having health policy sessions at SGIM meetings and greater online resources for active health policy issues.

During the next year, the SGIM Health Policy Committee plans to assemble a health policy curriculum in accordance with the Member Outreach Subcommittee survey results. This curriculum will be guided by a newly created SGIM Health Policy Curriculum Advisory Board

composed of health policy experts as well as residents and fellows. The advisory board will lead the build out of the curriculum and ensure that the target audience—SGIM members—is being engaged throughout the process.

Based on the survey results, the health policy curriculum will have two domains. First, it will have an up-to-date list of active state and federal health policy issues along with SGIM's stance on issues as applicable. Second, it will have background information on core topics such as health care finance and the Affordable Care Act for SGIM members to view. Also, to address the needs of SGIM members as expressed through the survey, the newly formed advisory board will work collaboratively to set up health policy sessions at regional and national SGIM meetings.

SGIM is in a unique position to assemble health policy educational resources on a national level. SGIM is a professional organization that not only provides educational materials for members but also engages in advocacy efforts for its constituents. This health policy curriculum will enable SGIM members to develop expertise regarding health policy issues and participate in SGIM's advocacy efforts in support of general internal medicine with insight and perspective. This year we look forward to creating the SGIM Health Policy Curriculum Advisory Board and working toward constructing a national curriculum that is learner driven and engages SGIM members across the nation. We welcome your interest in this initiative. For more information, contact Ted Long at [theodore.long@gmail.com](mailto:theodore.long@gmail.com).

**SGIM**

# SARET

SUBSTANCE ABUSE RESEARCH EDUCATION AND TRAINING

**ABOUT THE PROGRAM**  
 SARET, the Substance Abuse Research Education and Training Program, is an innovative program designed to stimulate learners' interest and skills in exploring addiction research. Six interactive, self-directed online web modules offer state-of-the-art education on addiction and addiction research to students in the fields of medicine, nursing, dentistry and social work.

**BENEFITS TO STUDENTS AND FACULTY**

- Educates students on addiction and fundamentals of clinical research
- Provides engaging, self-directed learning activities
- Fills curricular gaps in SA-related content
- Interprofessional learning emphasized throughout

**SIX ONLINE LEARNING MODULES**  
 Exploring Substance Abuse Research; Personal Impact; Epidemiology; Neurobiology; Screening; Treatment Modalities

All materials available at no cost

**CONTACT**  
 Sewit Bereket, MPH  
 SARET Program Manager,  
 Dept. of Population Health  
 Sewit.Bereket@nyumc.org  
 212.263.0889

**CHECK IT OUT!**  
 To access the modules, please visit:  
[compass.med.nyu.edu/category/saret](http://compass.med.nyu.edu/category/saret)  
 Choose *Non-NYU Login*, then *Register*  
 ▶ For a 1-minute video overview, go to:  
[tinyurl.com/saret-video](http://tinyurl.com/saret-video)

NYU COLLEGE OF NURSING

NYU SILVER SCHOOL OF SOCIAL WORK

NYU COLLEGE OF DENTISTRY

NYU School of Medicine  
NYU LANGONE MEDICAL CENTER



## Become a “60-second” Advocate!

Francine Jetton, MA, and Mark D. Schwartz, MD

*Ms. Jetton is Director of Communications at SGIM, and Dr. Schwartz is chair of the Health Policy Committee.*

**F**eeling passionate about advocating for general internal medicine (GIM) but don't know how to start? Wondering how to get in touch with members of Congress to ask them to act on our behalf? Don't know what the issues are and how you can help? Feeling like you just don't have enough time in the day to take on one more project? SGIM can help you become a 60-second advocate!

SGIM's Health Policy Committee has long been dedicated to advocating for issues dear to GIM. Each year, members work to champion issues in education, research, and clinical practice like fair and equitable Medicare reimbursement policies, adequate funding for health professions training, and support for health services research. More than 50 members are active on four different subcommittees that meet on monthly subcommittee calls; work within ad hoc groups on specific initiatives; write articles, letters, and educational messages; and provide updates at SGIM regional and national meetings. And each year in March, SGIM members come to Capitol Hill en masse to put specific messages in front of their own representatives. The Committee is active and fun and provides a strong voice for SGIM in federal health policy.

So what can you do in 60 seconds that would help make a difference? The answer is—quite a bit. This year, SGIM has partnered with CongressWeb, a new software that allows SGIM members to petition Congress on behalf of specific legislation. You may have already seen e-mails from the Health Policy Committee that inform members about specific health policy issues.

To help members communicate directly with their representatives, additional e-mails are sent that allow members to send their representatives a tailored message on an issue in just a few clicks. This takes less than a minute and enables member voices to be heard on the Hill. This software also allows for members to deliver pre-formatted tweets to their representatives and share Facebook posts on SGIM's positions. Have another minute to spare? You can also send a pre-written letter to the editor for media outlets in your hometown alerting and educating others about an important policy issue.

In just 60 seconds of advocacy, you have actively participated in the democratic process. But what if you have a little more time? Visit the SGIM website's Advocacy 101 section (<http://www.sgim.org/communities/advocacy/advocacy-101>), and read through some topics to further your advocacy education. Briefs like “Getting Your Message Across in Congress” and “Understanding the Advocacy Process” will advance your learning. Once you have a better understanding of the process, there are links to key Congressional members and SGIM's specific advocacy positions. Our governmental relations firm, Cavarocchi-Ruscio-Dennis (CRD) Associates, LLC, publishes a monthly report to let SGIM members know exactly what is going on in Congress throughout the year. These reports can also be found online at <http://www.sgim.org/communities/advocacy/advocacy-reports>. Also online is a compendium of legislative endorsements from SGIM, which allows members to

SGIM has partnered with CongressWeb, a new software that allows SGIM members to petition Congress on behalf of specific legislation.

see how SGIM has responded to a variety of issues in the past.

Still want to learn more? Each year both regional and annual meetings have a great deal of advocacy content. At the annual meeting last month in Toronto, workshops like “Face-to-Face Advocacy 101: Visiting Your Elected Officials” and “Armchair Advocacy: An Op-Ed Writing Workshop” were presented alongside the Health Policy Interest Group meeting as part of the health policy/advocacy/social justice track. A health policy update is provided at each regional meeting, and health policy articles are included on a regular basis in *Forum*. Members of the Outreach Subcommittee are developing a project that brings together health policy curricula (see article by Ted Long) as a way to join educators interested in teaching health policy and advocacy to students across the country. And of course, we encourage all SGIM members to participate in SGIM's Hill Day each March.

We urge you to participate to amplify SGIM's voice in health policy—for 60 seconds, 60 minutes, or 60 years!

## The Difficult Discharge

Vina Pulido, MD

*Dr. Pulido is a resident in the Department of Medicine at Boston Medical Center.*

**W**orking as an intern at Boston Medical Center (BMC), formerly Boston City Hospital, I find that the “disposition” section of my progress note is, more often than not, a big question mark.

Mr. J was one such patient. He was a 74-year-old veteran who had been admitted with altered mental status, rhabdomyolysis, acute kidney injury, and possible herpes zoster ophthalmicus. He lived alone and rarely saw his two local children. He managed a myriad of health issues by himself, which meant he was not taking any of his prescribed medications for coronary artery disease, hypertension, hyperlipidemia, and vitamin B12 deficiency. Somehow he had already survived prostate cancer, bladder cancer, an NSTEMI, and a nephrectomy secondary to trauma—all the while abusing cocaine and alcohol.

The weeks leading up to his admission were truly a series of unfortunate events. At each stage, there was a fork in the path, and Mr. J always followed the one that led him to his inevitable admission. First, Mr. J saw an optometrist for conjunctivitis at the VA, where he received all his care. The conjunctivitis worsened despite treatment, and the optometrist became concerned about herpes zoster ophthalmicus. He pleaded with Mr. J to go to an emergency department (ED) for evaluation, and even called a taxi to Mr. J’s front door, but to no avail. Days later, when it became intolerable, Mr. J ended up at the BMC ED, which was closer to his apartment. Acyclovir was prescribed for his presumed herpes zoster ophthalmicus, but he did not pick up this prescription. A week went by. A friend became worried about Mr. J, who seemed confused over the phone. The friend finally called 911 for Mr.

J, who then arrived by ambulance at BMC for inpatient admission.

During his admission, Mr. J was seen by inpatient ophthalmology and neurology consultants and promptly received empiric IV acyclovir for presumed herpes zoster encephalitis. His rhabdomyolysis, thought to be due to a fall while altered, resolved with hydration. Cerebrospinal fluid analysis ultimately was inconsistent with herpes zoster encephalitis, so he was discharged on oral valacyclovir and ophthalmic antibiotic ointments. He had improved and wanted to leave the hospital, but it was never clear what his baseline functional status was, as his children did not see him often. What was evident was that he used to be an independent man, but it was unclear how long he had been declining prior to this acute illness.

Knowing Mr. J’s history, I was extremely worried about his discharge. This was a man who was stubborn enough to refuse help when ill, who did not take any of his prescribed medications, who missed multiple clinic visits, and who delayed taking any medications until his illness had progressed to the point of inpatient hospitalization. Moreover, on discharge, I discovered he had not filled out any of his insurance paperwork, so he could not afford the valacyclovir that had been prescribed on discharge, even though he was eligible for both Medicare and Medicaid. Essentially, he had been just barely independent enough to mislead his children into thinking he could take care of himself, until he fell off the precipice.

I did what I could to prepare for his discharge, which took hours. I set up a visiting nurse. I called his daughter to pick him up, despite the patient’s prideful protests that he wanted no one to be bothered. I

walked him and his daughter to the BMC pharmacy to pick up his prescribed medications, which ultimately could not be filled due to his lack of insurance. I called the VA on-call nurse practitioner to fill the valacyclovir for him and called him to let him know. He said, “No problem. I’ll have my son pick it up for me.” I set up an appointment for him at the VA within a few days of discharge and faxed the discharge summary to the VA. All the while, I waited in dread, hoping in my heart of hearts that whatever I did would be enough.

And, not unexpectedly, less than a week after discharge, Mr. J’s primary care physician sent him to the VA ED. He had not filled any of his prescriptions. He had sepsis secondary to a urinary tract infection. During this next hospitalization, he constantly refused treatments. Psychiatry saw him and concluded that he did not have capacity to refuse. They diagnosed him with a form of cognitive impairment without evidence of mood disorder. Over a month later, he remains at a VA long-term care facility because of concerns for his capacity to perform his activities of daily living.

I have had many patients like Mr. J in my six months as an intern at BMC. Patients who have too many comorbidities to manage alone. Patients who do not have the mental capacity to understand the severity of their illness but have sufficient insight to want a better quality of life than a hospital can provide. Patients who are too poor to afford a good long-term care facility. Patients who have no one to help them manage their numerous health care issues.

Mr. J was lucky in a way. Although he did not have insurance, he was a veteran, and the VA has excellent resources for difficult dis-

continued on page 13

## COMMENTARY

continued from page 1

policy into an enlarged entitlement program; and 3) getting stuck with a growing bill after 2019. These predominantly Southern or Midwestern states tend to be led by Republican governors or legislatures. They have greater numbers of uninsured citizens, greater poverty, lower educational achievement, and lower performance in state health rankings.

The decision to adopt or reject Medicaid expansion has significant health and economic consequences. A 2014 Massachusetts study found that for every 830 additional people who received coverage, one premature death was prevented.<sup>1</sup> Hospitals in states not expanding Medicaid coverage will have declining revenue since they will need to care for uninsured patients while losing their disproportionate share hospital (DSH) federal subsidy. DSH payments have offset uncompensated care and are set to decrease in the ACA. In contrast, hospitals in expansion states are already seeing a substantial decrease in the proportion of self-pay and charity care cases.

Making matters worse, 19 of the 23 states opting out of Medicaid have also chosen not to establish their own health insurance exchange. Instead their citizens rely on the federally run exchange for private health insurance on the individual market. This core ACA provision is now threatened by *King v. Burwell*, a case the US Supreme Court agreed to hear in early 2015. (The high court will issue its decision by June 2015.) The petitioners challenge the authority of the Internal Revenue Service (IRS) to subsidize health coverage purchased through insurance exchanges run by the federal government. They argue that Congress intended to limit federal tax credits to residents of states running their own insurance exchanges. Currently only 13 states and the District of Columbia oper-

ate exchanges on their own. Another 10 are in partnership with the federal government, and the rest are run by the federal government and would be threatened if the Court rules in favor of the plaintiff.

If the Court rules that subsidies in federal exchanges are not allowed, the IRS must stop paying such subsidies. Almost 5 million people are currently receiving subsidies in affected states, and this number will increase to 13 million by 2016. Many of those who could lose subsidies would no longer be required to have insurance because of an exemption for those who have to pay more than 8% of family income for premiums. This would topple the three-legged stool of guaranteed issue, mandated coverage, and premium support.

As we said in 2012, these forces may lead to a perfect storm for academic health centers in non-expanding states—continued large numbers of uninsured, loss of DSH payments, and no new cost-shifting to the insured to make up the difference.<sup>2</sup>

Because the potential impact on primary care is great and the bandwidth of our volunteer SGIM advocates is limited, lobbying efforts have been focused on national health policy. The Health Policy Committee (HPC) is willing to also lend support to local advocacy champions in states considering Medicaid expansion. State hospital associations<sup>3</sup> are actively advocating for coverage expansion since they agreed to substantial Medicare payment cuts in exchange for the promise of fewer uninsured patients. Local provider organizations<sup>4</sup> (e.g. American College of Physician chapters) offer another avenue for SGIM members to get involved in efforts to motivate State governors and legislatures to support Medicaid expansion as a health and economic issue.

If the Court blocks premium subsidies on the federally run exchanges, many more SGIM

Many of those who could lose subsidies would no longer be required to have insurance because of an exemption for those who have to pay more than 8% of family income for premiums.

members will have cause to advocate locally for the establishment of a state-run insurance exchange to maintain coverage and access for our patients.

Please contact the HPC if you desire our support in implementing state-focused advocacy.<sup>5</sup>

### References

1. Sommers BD, Long SK, Baicker K. Changes in mortality after Massachusetts health care reform: a quasi-experimental study. *Ann Intern Med* 2014; 160:585-93.
2. Moran WP, Sessums L, Schwartz MD. Refusing to expand Medicaid: truth and consequences. *SGIM Forum* 2012; 35(10):2,12.
3. American Hospital Association. State, regional, and metropolitan hospital associations. Available at: <http://www.aha.org/about/srmassoc/index.shtml> (accessed on January 12, 2015).
4. Health Guide USA. State medical societies and associations. Available at: [http://www.healthguideusa.org/state\\_medical\\_societies.htm](http://www.healthguideusa.org/state_medical_societies.htm) (accessed on January 12, 2015).
5. SGIM Health Policy Committee. <http://www.sgim.org/communities/advocacy>

SGIM

---

## ESSAY

continued from page 2

When fellow Illinoisans and I headed out to Capitol Hill, I was struck by how busy the place was. With appropriations season in full swing, the sidewalks and hallways were teeming with groups of sightseers, student groups, advocates, lobbyists, and bureaucrats all jostling to voice their opinions (or at least to take a selfie). Living in a democracy that provides such direct access to the legislative process has certain advantages but, as a consequence, obliges each of us to advocate for our interests lest they be drowned out by the other voices seeking attention.

In our meetings with Congressional and Senatorial legislative aides, my group (SGIM President-Elect Marshall Chin, MD; Anna Volerman, MD; and Tony Jiang, MD) pressed a variety of issues on SGIM's policy agenda including SGR repeal, restoration of Medicaid reimbursement parity, better accountability for GME funding, protection of PCORI from anti-Obamacare activism, and expansion of funding at the National Institutes of Health with a focus on the Clinical and Translational Sciences Award program. The legislative aides, despite varied levels of experience, were well in-

formed about the issues, polite, and interested in our perspective. It was empowering to sit in my elected representative's office while a staff member responded to my concerns.

For me there were a few surprises (evidently neurologists have been pressing to be recognized as primary care providers in reference to Medicare primary care bonus payments) and a few expected responses (passing a replacement to the SGR is going to be really expensive). On the whole, it seemed that there is support in Washington for efforts to improve primary care training, methods for reimbursement for primary care services, and funding for the health services research that guides our work. The details of how and when those goals will be accomplished remains to be seen, but I left each meeting with a new e-mail contact, a new perspective on my ability to influence reform, and the satisfaction of having voiced my opinion.

Speaking for myself, Hill Day changed my perspective on the value of political engagement and the responsibility I have as a physician to advocate for my patients. The future holds many challenges

for American health care. As an aging baby boom generation meets a physician workforce that is both undersized and unevenly distributed, the challenges of delivering high-value health care will only increase. In response, we will need thoughtful reimbursement, education, and research funding policies. Additionally, as health care organizations shoulder financial risk for the costs of care, physicians will soon find that policy concerns previously relegated to the realm of public health (such as environmental or tobacco regulations) are also directly connected to reimbursement. This alignment between the interests of health care providers and public health policymakers is equally important at the national, state, and local levels.

As I envision the future of my career as an academic primary care physician, I can see that I will be held increasingly accountable for the health outcomes achieved by my patients. From my perspective, as physician responsibilities encompass population health in addition to individual health, our advocacy responsibilities should expand from the individual level to the political as well.

SGIM

---

## EDUCATORS' CORNER

continued from page 6

*required to provide optimal cost-effective care, including training in evidence-based medicine, team-based care, and care coordination.*

5. *The GME system should provide incentives to align the practice patterns of graduates with national and regional workforce needs.* Health care systems built upon a robust primary care workforce produce better outcomes at lower costs than systems without a primary care base. Direct accountability by GME institutions—linking the receipt of GME dollars with workforce outcomes—would be

an important step to restoring a robust and sustained primary care base. To do that requires an incentive system that rewards institutions that demonstrate a sustained ability to train individuals who become primary care physicians.

6. *Funding should be available to foster innovation.* Over the past several decades, the capacity of medical thought and medical practice have changed profoundly, as have the demographics of disease. To remain apace, the federal government should support and test innovative education and

training models that allow GME to more readily adapt to practice in the 21st century. One approach would be the creation of a Center for Medical Training Innovation, the goal of which would be to use evidence to design and test innovative training programs intended to meet the changing health care needs of the nation.

Aligning GME with the nation's health care needs will not be an easy task, but if the president and Congress are serious, meaningful GME reform should be on their to-do list.

SGIM



---

## PRESIDENT'S COLUMN

continued from page 3

health care system, our care of patients, and the education of our trainees. It is crucial for us not to be complacent or passively accept the status quo. The famous story about hockey legend Wayne Gretzky comes to mind. When asked to explain what made him great, Gretzky replied: "I skate to where the puck is going to be, not where it has been." That's why we need to devise a strong strategic plan now.

While checking the wording of Gretzky's quote, I came across a number of his other sayings that are relevant for us now:

- "Procrastination is one of the most common and deadliest of diseases, and its toll on success and happiness is heavy."
- "You miss 100% of the shots you don't take."
- "Hockey is a unique sport in the sense that you need each and every guy helping each other and pulling in the same direction to be successful."

Who knew Wayne Gretzky was such a sage philosopher?

Let me share with you one of the directions SGIM will be going in this

year. A new initiative for SGIM will be a focus on population health, an emerging issue facing health care systems and organizations with major implications for GIM. Caring for populations is a new endeavor that impacts the care we provide patients. It requires of us new teaching methods and new research approaches and broadens the scope of what it means to be a physician. As the voice of GIM, SGIM can serve a pivotal role in development and implementation of the population health agenda. We are currently in the process of planning a conference dedicated to population health issues in conjunction with the American Academy of Pediatrics, the American Pediatrics Association, the Institute for Healthcare Improvement, and the Society of Teachers of Family Medicine. This conference will be a catalyst for future collaborations with these organizations on population health issues. Russ Phillips from Harvard and Leora Horwitz from New York University and the SGIM Research Committee have been doing an outstanding job as SGIM's leaders on this conference initiative. The theme of the SGIM 2016 annual meeting will also be population

health. I am delighted that Steven Simon of the Boston VA Medical Center and Harvard and Margaret Lo of the University of Florida have kindly agreed to chair and co-chair this meeting. Steven and Margaret have a long history of generous service to SGIM and are universally respected and well liked for their leadership and collegiality. I am looking forward to devoting a future *Forum* column to discussing population health with you in more detail.

Please contribute to the discussion on strategic priorities for SGIM during this crucial period. A discussion thread on GIM Connect is devoted to this topic, so please offer your thoughts and comments. We seek input from as many stakeholders as possible for this endeavor. At the annual meeting in Toronto, the SGIM Council and committee chairs engaged in a great conversation. We also received the wise advice of SGIM's past-presidents at their annual breakfast meeting. Your input is critical and your suggestions invaluable. On behalf of the SGIM Council and staff, thank you very much. We look forward to working with you on establishing SGIM's strategic direction.

SGIM

---

## HUMANISIM IN MEDICINE

continued from page 10

charges. He had children nearby who cared about him. He was not homeless or destitute. But now that he is ensconced in a long-term care facility, he has lost all semblance of independence, which is a heavy price to pay for health.

But what is the end point for Mr. J? He could not live alone any longer, but he did not want to live in a hospital setting for the rest of his life. He was growing older, with all the incumbent infirmities of old age. He did not want to burden his children, and they had their own busy lives and jobs. In this day and age, we are all just trying to figure out "how ordinary people can age without having to choose between neglect and insti-

tutionalization," as Atul Gawande insightfully writes in his new book *Being Mortal*.<sup>1</sup> This is made even more difficult when patients have limited financial resources, as do most of my patients at BMC.

There is no easy answer. We are entering the era of longevity and infirmity. We need more geriatricians at a time when fewer are being trained.<sup>2</sup> We need better assisted living facilities that can navigate the perilous path between inadequate support for independent living and institutionalization. We cannot force medications and check ups on patients like Mr. J, but we also cannot let them waste away due to stubborn self-neglect.

While Mr. J is no longer under my care, I have many more patients like him waiting for placement. This is not something medical school prepared me for, and I am learning slowly day by day. Medicine is an ever-changing landscape, and despite the frustrations and challenges, I am still grateful to be a part of it.

### References

1. Gawande A. *Being mortal: medicine and what matters in the end*. New York: Metropolitan Books, 2014.
2. Span P. Even fewer geriatricians in training. *New York Times*, January 23, 2013.

SGIM

## SIGN OF THE TIMES

continued from page 7

centers) and \$44.34 for non-facility practices per patient per calendar month (not per 30 days). Patients will be liable for 20% of this per usual Medicare rules. This works out to \$395.28 per patient per year for four hours of care spread evenly over 12 months at a facility (e.g. hospital based) practice and \$532.08 for a non-facility (e.g. community or private office) practice. For the hospital-based practice, with an overhead (conservatively) at 50%, this calculates to an hourly payment rate of roughly \$50. Since the requirement is for a minimum of 20 minutes per month, those with higher care management needs will consume resources that are not compensated.

Will this be sufficient? A practice with a high level of efficiency, a large Medicare enrollment, and the ability to distribute CCM work to existing

staff could employ these codes with the appropriate workflow redesign and EHR support. Smaller practices may struggle due to the distractions the detailed CCM documentation expectations would add. No one will likely hire new staff without knowing that the costs will be fully covered. As a result, the CCM code may have limited appeal. It is possible that there will not be any payment available for the supervising physician despite the chronic conditions oversight expectations, the need to negotiate and update the plan of care, 24/7 access, and the time spent with staff supervision.

As with all new codes, CMS will be monitoring the use of CCM. SGIM members should be mindful that this code is not necessarily payment for work already being done since there are significant added ex-

pectations and personnel requirements. That said, a robust response to the CCM code will send a powerful message to CMS and Congress that the primary care community is committed to comprehensive and continuous care. With increased utilization, there will be opportunities to advocate for expanded payments for the most complex patients.

### References

1. Edwards ST and Landon BE. Medicare's chronic care management payment—payment reform for primary care. *N Engl J Med* 2014; 371:2049-51.
2. <https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory>

SGIM

**Table 1. Brief Summary of Chronic Care Management Code 99490**

#### Which patients:

- Any Medicare patient with at least two chronic medical conditions, estimated up to 70% of all Medicare patients

#### Practice capabilities:

- EHR, MU certified 2011 or 2014
- 24/7 coverage
- Telephonic and asynchronous electronic communication

#### Scope of services:

- Continuity of care, one accessible primary physician (or NP/PA if the primary clinician) identified for each patient
- Routine health maintenance and disease prevention (screening, vaccinations, etc.)
- Oversight of chronic condition management (condition-specific monitoring)
- Medication oversight (compliance, interactions, reconciliation at transitions of care, patient understanding)
- Care coordination (home health care covered by the VNA supervision code HCPCS G0181 and the hospice care code HCPCS G0182) cannot be submitted if the CCM code is submitted and vice versa.
- Transitions of care oversight (Outside of those covered by TCM service codes 99495-6 cannot be submitted if the CCM code is submitted and vice versa.)

#### Documentation:

- Plan of care (POC) developed jointly between the patient and the primary care physician (or NP/PA if the primary clinician) and updated over time, no stipulated interval
- Contract signed and scanned, no need for periodic renewal
- Patient summary, electronically accessible to all covering physicians
- 20 minutes total per calendar month, documentation time included

#### Payment:

- \$32.94 per calendar month for facility (e.g. academic medical centers) and \$44.34 for non-facility practices; patient responsible for 20%, which would be covered by Medicare supplemental insurance

For those interested in writing for *Forum*, here is a list of the department headings we use with descriptions of each.

### **SGIM Forum Departments**

1. **Annual Meeting Update:** Features seasonal content that highlights the annual meeting.
2. **Best Practices:** Relates to quality improvement in all areas of clinical medicine and medical education.
3. **Clinical Update:** Describes current and emergent topics of interest in clinical practice.
4. **From the Editor:** Includes monthly/semi-monthly thought pieces from the current editor.
5. **From the Regions:** Describes regional meetings and their keynote speakers, awardees (i.e. presentations and posters), and clinical topics.
6. **From the Society:** Covers issues such as leadership initiatives, membership surveys, and capital campaigns that affect the general membership.
7. **Health Policy Corner:** Covers health policy developments of interest to faculty in general internal medicine, including health care reform, advocacy, health systems redesign, funding issues, and health care disparities.
8. **In Conversation:** Includes interviews with notable figures in general internal medicine.
9. **Leadership and Healthcare Administration:** Explores topics of interest to those in leadership positions as well as those who aspire to these roles.
10. **Medical Education:** Describes topics of interest to medical students, residents, fellows, and clinician-educators, including residency training, fellowship opportunities, curriculum development, writing and publishing, mentorship, and faculty development.
11. **Medical Humanities:** Provides an outlet for creative writing by members, residents, and medical students.
12. **Morning Report:** Involves a presenter and discussant who describe an interesting clinical scenario.
13. **Perspective (includes Editorial/Commentary/Essay/Point-Counterpoint):** Presents thought pieces written by SGIM members. Point-Counterpoint is designed to cover two perspectives on a controversial issue.
14. **President's Column:** Includes monthly thought pieces from the current Society president.
15. **Researchers' Corner:** Describes work of interest to clinician-researchers, including research methods, study design, grant writing, funding opportunities, and opportunities to collaborate on research projects.
16. **Sign of the Times:** Addresses changing perspectives in general internal medicine including new twists on old concepts—e.g. graduate medical education, primary care redesign, etc.
17. **Task Force Update/Interest Group Update:** Provides news from task force and interest groups of interest to Society members.
18. **Technology Update:** Describes innovations in technology including electronic medical records, smart apps, social media, and tools for practice management and patient care.



### **SGIM Forum: Call for Editorial Board Members**

#### **Expectations:**

1. Participate in conference calls (1 per month)
2. Contribute 10 to 12 articles per year
  - Solicit articles from your contacts throughout SGIM
  - Write your own article
3. Represent *Forum* at the local and regional level

*Working as an associate editor for Forum is a great opportunity to meet and collaborate with SGIM members from academic institutions throughout the United States and the world!*

For more information, contact:

#### **Karen R. Horowitz, MD, FACP**

Editor.SGIMForum@gmail.com  
*Editor in Chief, SGIM Forum*

#### **Francine Jetton**

jettonf@sgim.org  
*Director of Communications and Publications, SGIM*

# **SGIM** **FORUM**

*Society of General Internal Medicine*  
1500 King Street Suite 303  
Alexandria, VA 22314  
202-887-5150 (tel)  
202-887-5405 (fax)  
[www.sgim.org](http://www.sgim.org)