Want to be “in the room where it happens”? It starts with standing for something.

ACP Northern California Chapter
October 12, 2019
The room where it happens.

The scene:
Alexander Hamilton, Thomas Jefferson and James Madison meet over dinner in NYC, and emerge with an agreement to locate the nation’s capital (to Virginia) and Hamilton’s plan for a central banking system.

Aaron Burr is not invited.
The room where it happens

*Burr:*
Two Virginians and an immigrant walk into a room

*Burr and Ensemble:*
Diametric'ly opposed, foes

*Burr:*
They emerge with a compromise, having opened doors that were

*Burr and Ensemble:*
Previously closed

*Ensemble:*
Bros

*Burr:*
The immigrant emerges with unprecedented financial power
A system he can shape however he wants
The Virginians emerge with the nation's capital

And here's the pièce de résistance:
No one else was in
The room where it happened
The room where it happened
The room where it happened
No one else was in
The room where it happened (The room where it happened)
The room where it happened
The room where it happened (The room where it happened)
No one really knows how the game is played
(Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens (Assume that it happens)
But no one else is in
The room where it happens (The room where it happens)
But what did Burr stand for?

HAMILTON/JEFFERSON/MADISON/WASHINGTON:

What do you want, Burr?
What do you want, Burr?

*If you stand for nothing
Burr, then what do you fall for?*
What can *Hamilton* teach us about advocacy?

*If you stand for nothing, what do you fall for?*

What does ACP stand for?
What do we stand for?

The following statements are not official ACP policy, as approved by the Board of Regents. They characterize (in my own words) what the College stands for, based on approved policies.

1. That advocacy must always put the interests of patients above all else.

2. That everyone should have coverage for the care they need, at a cost they, and the country, can afford.
What do we stand for?

3. That physicians have a responsibility to advocate for policies to lower costs without compromising care; to practice high-value, cost-effective care themselves, and be accountable for it.

4. That physicians and patients must be freed of unnecessary administrative tasks that take time away from patient care, contribute to professional burn-out, and impose enormous system- and practice-level costs.
What do we stand for?

5. That technology should support patient care and not detract from it.

6. That a well-trained internist will be shown to be the best value in American medicine.

7. That public policy must support the training, retention, and well-being of internists, and the overall primary care physician workforce, as being essential to good outcomes of care and lower costs.
What do we stand for?

8. That practices and delivery systems must center on what is best for patients and families, and be supportive of internists and other clinicians within those systems.

9. That patients and physicians benefit from having a choice of practice models, from large groups to small independent practices, and those choices should be supported.

10. That internists must be compensated for their services at a level commensurate with their value.
What do we stand for?

11. That the medical profession has a responsibility to advocate for policies to address social determinants of health, the environment, discrimination, tobacco and substance use, public health, inequality, gun violence, immigration and other societal issues affecting the health of patients and the public.

12. That all persons, without regard to where they live or work; their sex or sexual orientation; gender or gender identity; race, ethnicity, faith, or country of origin; must have equitable access to high quality medical care, and must not be discriminated against based on such characteristics.
We stand for policies to:

- Lower the High Cost of Prescription Drugs
- Address the Epidemic of Firearms-Related Injury and Death
- Expand Coverage and Stabilize the Insurance Market
- Fund Federal Workforce, Medical and Health Services Research, Public Health Initiatives
- Protect patients from surprise bills
- Improve Physician Payment under Medicare
- Reduce Unnecessary Administrative Tasks on Physicians and Patients
- Support Healthy Women and Families
- Support Medical Education and Reduce Student Debt
We stand for policies to reduce injuries and deaths from firearms.

- ACP advocacy is driving the national debate
- Spawning the #ThisIsOurLane movement.
What does ACP recommend to curb injuries and deaths from firearms?

- New [policy paper](#) updates 2015 policy paper.
- The paper does not threaten the 2nd amendment right to own firearms for personal defense or recreation. Rather, we seek to:
  - To keep guns out of the hands of felons, all convicted domestic violence abusers (whether against a person within their house or outside of it), those with temporary as well as permanent restraining orders, and persons at imminent risk of harm to themselves or others
  - Background checks for all sales.
  - Close domestic violence loopholes.
  - Extreme risk protection laws
  - To require safe storage of guns and ammunition
  - To prohibit sales only of “assault” rifles and large capacity magazines.
  - To study causes and solutions to reduce injuries and deaths.
NRA Response to new ACP Policy Paper sparked *This is Our Lane* movement

- In response to the most recent ACP policy recommendations on reducing firearm-related injuries and deaths published in *Annals*, the NRA tweeted saying physicians should “stay in their lane.”

- Physicians were quick to respond...
Our Response

The @NRA lectures on the "gun lanes" and not speaking with @ACPInternists policies, while @AnnalsofIM, has the evidence to be. Read & add your voice.

@NRA Someone should tell self-important articles in Annals of Internal Medicine articles, however, the medical community agrees bit.ly/Annals

6:23 PM - 7 Nov 2018 from Washington D.C.
61 Retweets 116 Likes

The @NRA tells us to stay in its own lane and out of the exam room. Take a stand today! Please click bit.ly/2Qr7L0N and make the commitment to talk to your patients about gunviolence. Evidence shows that your counsel could save a life #ThisisMyLane #ThisIsOurLane

6:59 AM - 9 Nov 2018
960 Retweets 2,001 Likes
Public Response

@MaggieFox: The @NRA tells doctors to shush and run their business. Doctors like @EstherChooMD MPH are very much the opposite. @CDCgov release.

@EstherChooMD MPH: We are not self-important: we are devoted to the care of others. We are not anti-gun: we are doctors in our patients’ care. We consult with everyone but most upsetting, actually, is the disability from gun violence which is unparalleled in the world.

@NRA: Someone should tell self-important, anti-gun doctors that gun deaths rose in 2015 after failing to consult the medical community. The medical community seems to have consulted NO ONE but themselves. nrra.org/articles/20181...

@JosephSakran: As a Trauma Surgeon and survivor of #GunViolence I cannot believe the audacity of the @NRA to make such a divisive statement.

We take care of these patients everyday. Where are you when I’m having to tell all those families their loved one has died. @DocsDemand #Docs4GunSense

@NRA: Someone should tell self-important, anti-gun doctors to stay in their lane. Half of the articles in Annals of Internal Medicine are pushing for gun control. Most upsetting, however, the medical community seems to have consulted NO ONE but themselves. nrra.org/articles/20181...

@Baltimore, MD: 2:59 PM - 7 Nov 2018
First patient, first wound to the head. The mother cried in longing to save him. The last one eluded us. #ThisIsOurLane

Dave Morris
@traumado

Can’t post a patient in this condition. This is what it looks like. @NRA @Joseph

Breathless
@breathless2

Replying to @NRA

Now, why in the hell do you think you have something against guns? Sort of like the trouble you have with life? #ThisIsOurLane #GunControl

Julius Cheng, MD MPH
@ChengJS_MD

Here’s hoping that the .@NRA and .@AnnCoulter realize that this is the reality we face. We seek solutions, and we won’t quit because lives depend on it. Help us with bulletholecontrol. Join us. #ThisIsOurLane #TraumaShoes #TraumaSurgery @EAST_TRAUMA @traumadoctors @DocsDemand
ACP’s position paper on reducing firearm-related injuries and deaths published in *Annals* has received extensive coverage in light of the NRA tweet saying physicians should “stay in their lane.” ACP, and the position paper, was mentioned in several top-tier media outlets, including CNN and CBS.

“For more than 20 years, the American College of Physicians (ACP) has advocated for the need to address firearm-related injuries and deaths in the United States.”

“...a public health crisis that requires the nation's immediate attention.”

“DOCTORS TAKE ON NRA OVER GUN VIOLENCE”
Firearms Position Paper Response: Top-Tier Media Coverage

The New York Times
Doctors Revolt After N.R.A. Tells Them to ‘Stay in Their Lane’ on Gun Policy

TIME
Doctors Slam NRA's Directive to 'Stay in Their Lane' After Chicago Hospital Shooting

HUFFPOST
‘This Is Our Lane’: Doctors Slam NRA After Chicago Hospital Shooting

AP
It’s a Twitter war: Doctors clash with NRA over gun deaths

The Wall Street Journal
After NRA Rebuke, Many Doctors Speak Louder on Gun Violence

The Guardian
#ThisIsOurLane: NRA’s criticism spurs doctors to speak out on gun violence

NPR
After NRA Mocks Doctors, Physicians Reply: ‘This Is Our Lane’
Reduce injuries and deaths from firearms.

Universal background checks

Funding for research

Intimate Partner Violence

Safe Storage

Access to Mental Health treatment

Extreme Risk Protection Laws

Physician counseling and “Gag Laws”

 Firearms with Features designed to increase their rapid and extended killing capacity
You need to stand for something to be in the room where it happens. *But that’s not enough.*

You also have to know “how the sausage is made”
Believing in something is essential. But you also have to know “how the sausage is made”

Burr:

No one really knows how the game is played (Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens
But no one else is in the room where it happens
ACP knows “how the sausage is made”

- Coalition-building (Group of 6): ACP, AAFP, AAP, APA, AOA, ACOG: represents over 560,000 physician and medical student members!
- Lobbying: congressional and regulatory branches
- Judicial branch: lawsuits and amicus briefs
- Grass roots (AIMn and Leadership Day)
- Earned and social media
- And of course, evidence-based policy positions

We do it all. We do it well.
We’re in the room where it happens

- The White House, HHS, and Congress regularly consult with us on a wide range of issues, from opioids, to Medicare payment policies, to immigration, to GME and workforce, to regulatory relief, to coverage, to public health, to gun violence—the list goes on and on.

- Even when we disagree, we are invited because ACP is viewed as a respected, credible, and evidence-based organization that stands for policies to improve the lives of patients, and daily work of our physicians.
We’re in the room where it happens

ACP President Robert McLean,
On Capitol Hill with the Group of 6

ACP’s Shari Erickson discusses Medicare payment policy with CMS administrator Seema Verma

LD attendees with Rep. Ami Bera, D-CA
Case study of *being in the room where it happens*: improving payments for internists’ cognitive care

- Major wins in the proposed Medicare physician rule! If finalized:
  - Reverses CMS proposal to collapse E/M code payments and de-value complex cognitive care
  - Accepts RUC recommendations to improve RVUs and payments for office visit codes (ACP lead the multi-specialty efforts to survey physicians and make the case for higher payments)
  - Reduces documentation of E/M services
  - Improves payments for care management services
Background

- In November 2018, CMS released the 2019 Medicare Physician Payment Schedule Final Rule outlining a new E/M payment structure proposal—including blended payment rates for office-based/outpatient E/M visit levels 2 through 4 and separate payment for level 5 office visits.
In the room where it happens

ACP leaders and staff meet with CMS Administrator Seema Verma to discuss E/M payments and documentation, Patients Before Paperwork, and EHR interoperability. June 2018
Proposed changes in Medicare payments to physicians would recognize the value of cognitive services in providing quality patient care. Improvements include:

- Increased payments for evaluation and management (E/M) services
- Retained separate payment levels for E/M codes
- Improved documentation for E/M services
- Improved accuracy in tracking time spent
- Payment for managing opioid use disorder
- Additional add-on codes
Previous CMS Proposal:

<table>
<thead>
<tr>
<th>Complexity Level under CPT</th>
<th>Current (2018) Payment Amount</th>
<th>Revised Payment Amount***</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$76</td>
<td>$130</td>
</tr>
<tr>
<td>Level 3</td>
<td>$110</td>
<td>$143</td>
</tr>
<tr>
<td>Level 4</td>
<td>$167</td>
<td>$197 (at 38 minutes)</td>
</tr>
<tr>
<td>Level 5</td>
<td>$211</td>
<td>$211</td>
</tr>
<tr>
<td>Established Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$45</td>
<td>$90</td>
</tr>
<tr>
<td>Level 3</td>
<td>$74</td>
<td>$103</td>
</tr>
<tr>
<td>Level 4</td>
<td>$109</td>
<td>$157 (at 34 minutes)</td>
</tr>
<tr>
<td>Level 5</td>
<td>$148</td>
<td>$148</td>
</tr>
</tbody>
</table>
ACP was a leader, along with several other specialty societies, in creating a coalition to push to improve payments for the historically undervalued E/M services, by retaining separate payment levels for each of the E/M codes, and revising the code definitions.

ACP’s representative to the RUC, Dr. Bill Fox (also, chair-elect, Board of Governors) presented the coalition’s recommendations, which were accepted by the RUC, and now CMS!
In the room where it happens

ACP’s Dr. Bill Fox at RVS Update Committee, April 26, 2019 (2nd from right)
CMS’s Proposed Changes E/M

CMS proposes to assign separate payment rather than a blended rate, to each of the office/outpatient E/M visit codes (except CPT code 99201, which will be deleted)

Payment for a new prolonged visit add-on CPT code (CPT code 99XXX).
## Proposed E/M wRVU Changes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Current Work RVU</th>
<th>New Work RVU</th>
<th>Work RVU Increase</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>New Pt, straightforward medical decision making, 15-29 min day of visit</td>
<td>0.93</td>
<td>0.93</td>
<td>0%</td>
<td>22 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>New Pt, low level medical decision making, 30-44 min day of visit</td>
<td>1.42</td>
<td>1.60</td>
<td>13%</td>
<td>40 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>New Pt, moderate level medical decision making, 45-59 min day of visit</td>
<td>2.43</td>
<td>2.60</td>
<td>7%</td>
<td>60 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>New Pt, high level medical decision making, 60-74 min day of visit</td>
<td>3.17</td>
<td>3.50</td>
<td>10%</td>
<td>85 minutes</td>
</tr>
<tr>
<td>99211</td>
<td>Est Pt, Supervision</td>
<td>0.18</td>
<td>0.18</td>
<td>0%</td>
<td>7 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Est Pt, straightforward medical decision making, 10-19 min day of visit</td>
<td>0.48</td>
<td>0.70</td>
<td>46%</td>
<td>18 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Est Pt, low level medical decision making, 20-29 min day of visit</td>
<td>0.97</td>
<td>1.30</td>
<td>34%</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Est Pt, moderate level medical decision making, 30-39 min day of visit</td>
<td>1.50</td>
<td>1.92</td>
<td>28%</td>
<td>49 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Est Pt, high level medical decision making, 40-54 min day of visit</td>
<td>2.11</td>
<td>2.80</td>
<td>32.8%</td>
<td>70 minutes</td>
</tr>
<tr>
<td>99XXX</td>
<td>Prolonged visit new/est pt, add'l 15 min</td>
<td></td>
<td>0.61</td>
<td>New</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
Documentation Changes

- History and Exam would no longer be used for code selection; but are performed and documented as medically appropriate.

- Medical Decision Making (MDM) or Total Time on the Date of the Encounter may be used for code selection
  - (without regard to whether counseling and coordination of care dominate the service).
Care Management Services

- Prolonged services: add-on code was created. A minimum of 15 minutes is required for each unit of this code.

- Complex Chronic Care Management (CCCM)
  - The agency propose to adopt two G codes for complex chronic care management services in place of the two existing CPT codes.
  - Revising what must be included in the comprehensive care plan.

- Principle Care Management
  - CMS proposes to create two new payable codes for Principle Care Management (PCM) services, which would entail providing care management services to patients with a single serious, high-risk condition.
To recap:

- Advocacy requires that *you be in the room where it happens* whenever decisions are made.

- To be *in the room where it happens*, you have to know *what you stand for*.

- You need to know *how the sausage is made*: coalition-building, grass roots, traditional and social media, evidence-based policy, lobbying, engaging with regulatory agencies—and relationships and trust built over many years.
ACP is in the room where it happens

- Because we know what we stand for.
- And know how the sausage is made.