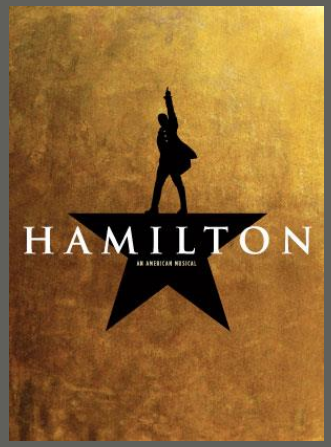
Want to be "*in the room where it happens*"? It starts with standing for *something.*

Missouri Chapter, American College of Physicians
September 21. 2019



American College of Physicians
Leading Internal Medicine, Improving Lives

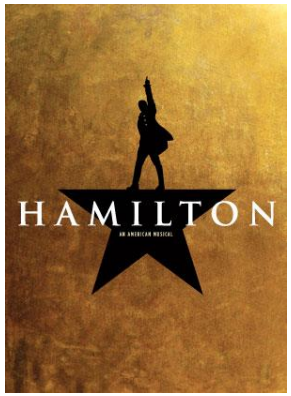
Bob Doherty, SVP, Governmental Affairs and Public Policy

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 patients and physicians, by urging Congress to take action on the following priorities:

- Lower the High Cost of Prescription Drugs
- Address the Epidemic of Firearms-Related Injury and Death
- Expand Coverage and Stabilizing the Insurance Market
- Fund Federal Workforce, Medical and Health Services Research, Public Health Initiatives
- 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
- Protect patients from surprise bills

We stand for policies to reduce Rx costs.

- Increase transparency and accountability in prescription drug pricing and improve access to lower-cost generic medications by co-sponsoring/supporting:
  - The *Fair Accountability and Innovative Research (FAIR) Drug Pricing Act* (H.R. 2296/S. 1391), which would require drug companies to disclose and provide more information about imminent drug-price increases, including data about research and development costs.
  - The *Reforming Evergreening and Manipulation that Extends Drug Years*, REMEDY Act (S. 1209), to aid in the approval of more generic drug applications by the FDA and therefore improve patient access to those medications.
  - The *Prescription Drug STAR Act* (H.R. 2113), to promote drug pricing transparency by requiring manufacturers to justify and explain price spikes on their drugs as well as reveal the price and quantity of the drug free samples that they give to clinicians.
  - The *Medicare Prescription Drug Price Negotiation Act of 2019* (H.R. 275/S. 62), to allow the federal government to negotiate lower drug prices on behalf of Medicare beneficiaries.
  - The *Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act of 2019*, (H.R. 965/S. 340), to prevent egregious practices by manufacturers that keep generic drugs from coming to the market.

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?

POSITION PAPER

Annals of Internal Medicine

Reducing Firearm Injuries and Deaths in the United States: A Position Paper From the American College of Physicians

Renee Butkus, BA; Robert Doherty, BA; and Sue S. Bornstein, MD; for the Health and Public Policy Committee of the American College of Physicians*

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. Yet, firearm violence continues to be a public health crisis that requires the nation's immediate attention. The policy recommendations in this paper build on, strengthen, and expand current ACP policies approved by the Board of Regents in April 2014, based on analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence.

Ann Intern Med. 2018;169:704-707. doi:10.7326/M18-1530 Annals.org
For author affiliations, see end of text.
This article was published at Annals.org on 30 October 2018.

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. In 2014, the ACP published a comprehensive set of recommendations (1). In 2015, it joined the American College of Surgeons, American College of Obstetricians and Gynecologists, American Public Health Association, American Psychiatric Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, and American Bar Association in a call to action to address gun violence as a public health threat, which was subsequently endorsed by 52 organizations that included clinician organizations, consumer organizations, organizations representing families of gun violence victims, research organizations, public health organizations, and other health advocacy organizations (2). Yet, firearm violence remains a problem–firearm-related mortality rates in the United States are still the highest among high-income countries (3).

Firearm violence continues to be a public health crisis in the United States that requires the nation's immediate attention. The ACP is concerned about not only the alarming number of mass shootings in the United States but also the daily toll of firearm violence in neighborhoods, homes, workplaces, and public and private places across the country. The policy recommendations in this paper build on, strengthen, and expand current ACP policies approved by the Board of Regents in April 2014 (1) and are based on an analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence. The ACP has long advocated for policies to reduce the rate of firearm injuries and deaths in the United States and once again calls on its members, nonmember physicians, nonphysician clinicians, policymakers, and the public to take action on this important issue.

See also:
Related article 734
Editorial comments 723, 725

Methods

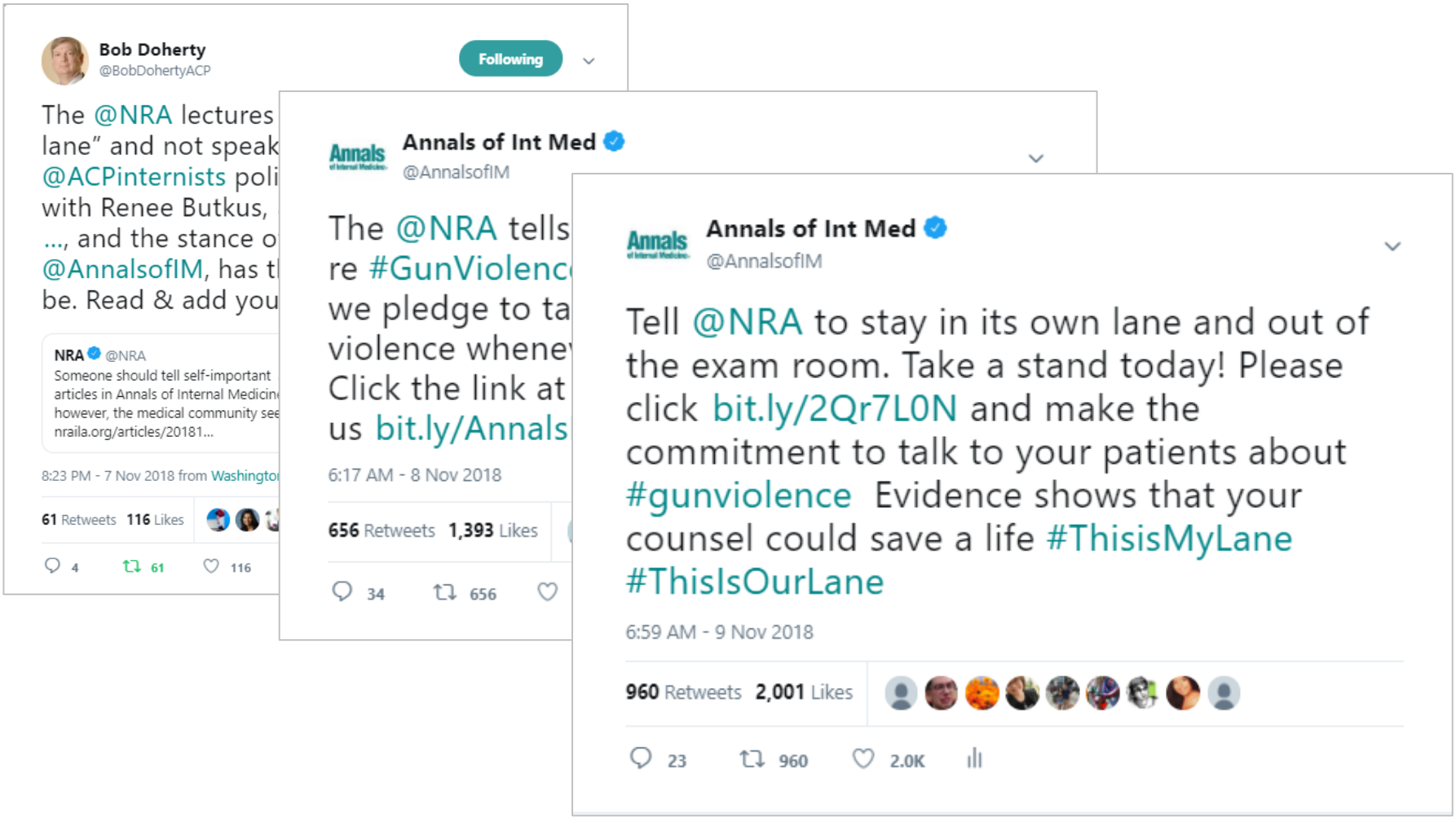
This policy paper was drafted by the Health and Public Policy Committee of the ACP, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties. The paper builds on, strengthens, and expands current ACP policies approved by the Board of Regents in April 2014 (1). The authors determined that many positions were still relevant and did not revisit those positions or the evidence supporting them. They identified gaps in policy and existing positions that needed to be strengthened, clarified, or expanded on the basis of emerging research and new initiatives on which the ACP did not have clear policy. The authors focused solely on evidence related to the new or modified recommendations and reviewed available studies, reports, and surveys related to firearm violence from PubMed, Google Scholar, relevant news articles, policy documents, Web sites, and other sources. Recommendations were based on reviewed literature and input from the ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The policy paper and related recommendations were reviewed and approved by the ACP Board of Regents on 21 July

- 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



Public Response

Maggie Fox @maggiemfox

The @NRA tells d
their business. Do
@JosephSakran s
are very much the
@CDCgov release

'We are not anti-gun; we are a
Gun deaths rose in 2015 after fa
nbcnews.com

11:31 AM - 8 Nov 2018

235 Retweets 436 Likes

11 235 436

Esther Choo MD MPH @choo_ek

We are not self-important: w
to the care of others
We are not anti-gun: we are
in our patients
We consult with everyone bu
Most upsetting, actually, is c
disability from gun violence
unparalleled in the world

> **NRA** @NRA
> Someone should tell self-important anti-gun doctors
> articles in Annals of Internal Medicine are pushing fo
> however, the medical community seems to have cons
> nraila.org/articles/20181...

6:03 AM - 8 Nov 2018

4,068 Retweets 12,646 Likes

212 4.1K 13K

Joseph Sakran @JosephSakran Follow

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** @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. nraila.org/articles/20181...

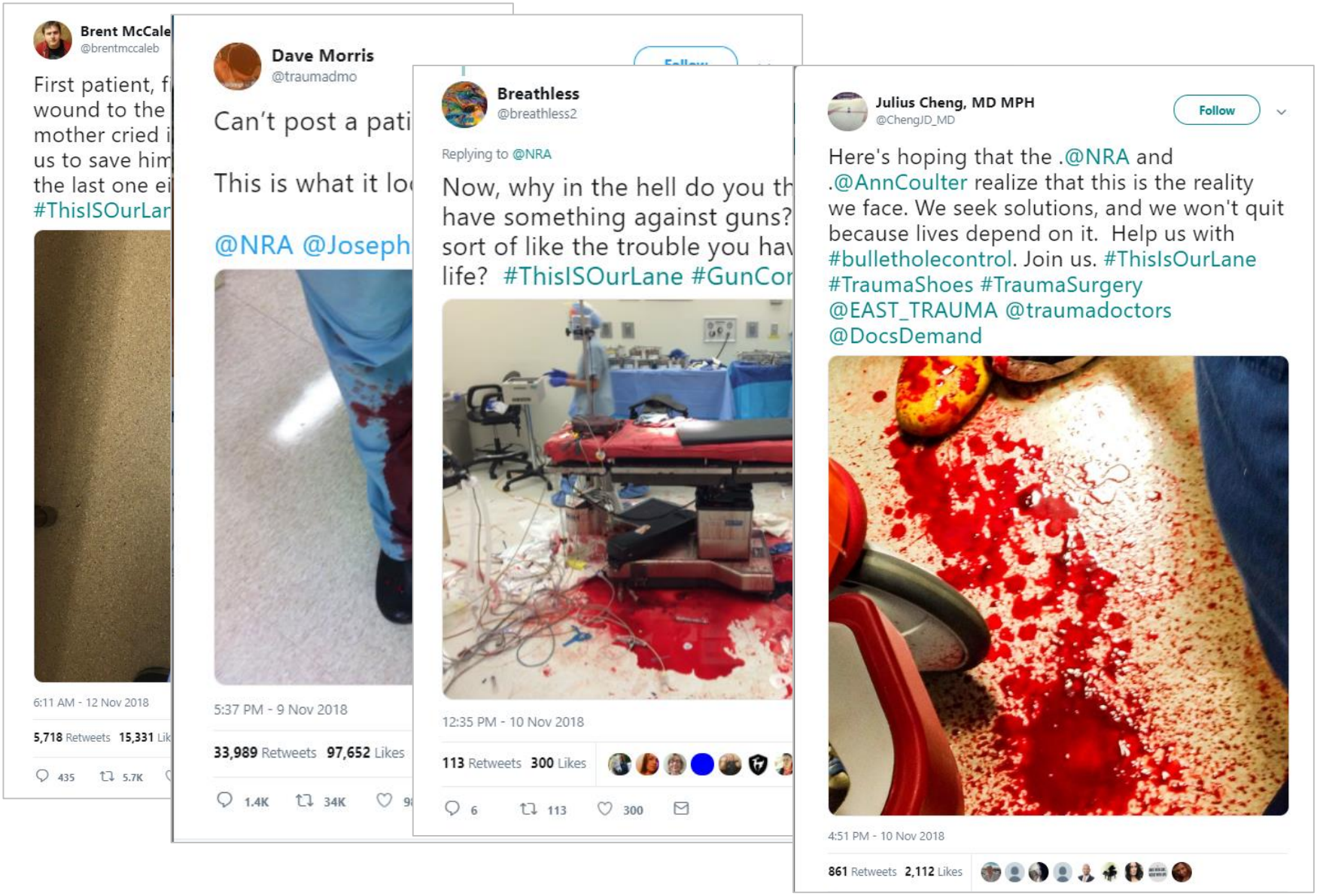
2:59 PM - 7 Nov 2018 from Baltimore, MD

11,797 Retweets 29,368 Likes

613 12K 29K

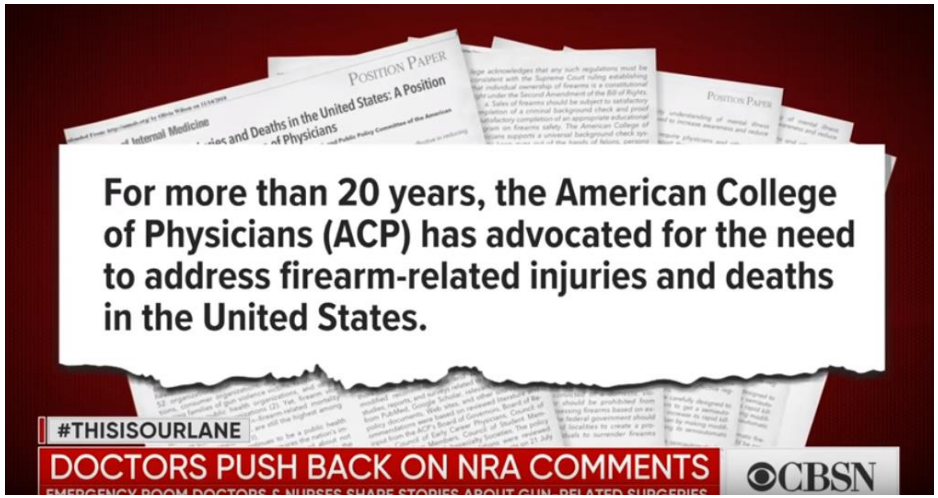
Annals Tweet your reply

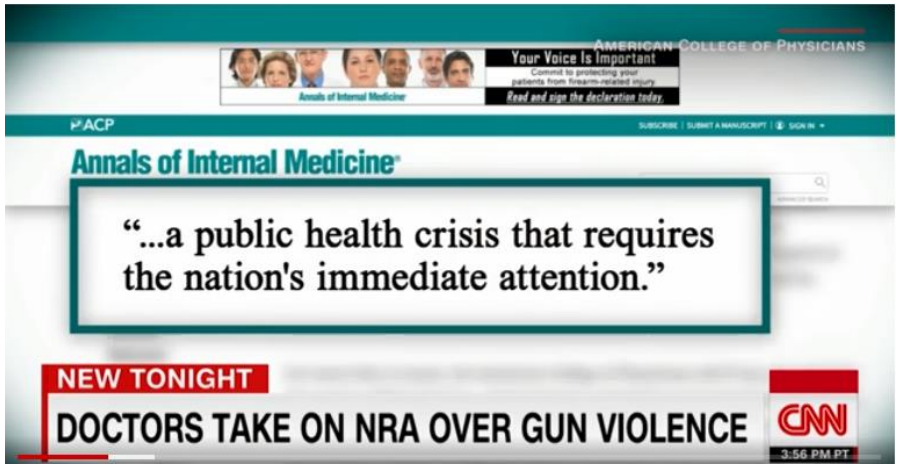
#ThisIsOurLane



Firearms Position Paper Response

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.





Firearms Position Paper Response: Top-Tier Media Coverage

Reduce injuries and deaths from firearms.

- New *Call to Action* from ACP, American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons, American Medical Association, and the American Public Health Association, published August 7, 2019, Annals of Internal Medicine.

Annals of Internal Medicine

SPECIAL ARTICLE

Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations

Robert M. McLean, MD; Patrice Harris, MD; John Cullen, MD; Ronald V. Maier, MD; Kyle E. Yasuda, MD; Bruce J. Schwartz, MD; and Georges C. Benjamin, MD

Shortly after the November 2018 publication of the American College of Physicians' policy position paper on reducing firearm injury and death (1), the National Rifle Association tweeted:

> 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.

Within hours, thousands of physicians responded, many using the hashtags #ThisIsOurLane and #ThisIsMyLane, and shared the many reasons why firearm injury and death is most certainly in our lane. Across the United States, physicians have daily, first-hand experience with the devastating consequences of firearm-related injury, disability, and death. We witness the impact of these events not only on our patients, but also on their families and communities. As physicians, we have a special responsibility and obligation to our patients to speak out on prevention of firearm-related injuries and deaths, just as we have spoken out on other critical public health issues. As a country, we must all work together to develop practical solutions to prevent injuries and save lives.

In 2015, several of our organizations joined the American Bar Association in a call to action to address firearm injury as a public health threat. This effort was subsequently endorsed by 52 organizations representing clinicians, consumers, families of firearm injury victims, researchers, public health professionals, and other health advocates (2). Four years later, firearm-related injury remains a problem of epidemic proportions in the United States, demanding immediate and sustained intervention. Since the 2015 call to action, there have been 18 firearm-related mass murders with 4 or more deaths in the United States, claiming a total of 288 lives and injuring 703 more (3).

With nearly 40 000 firearm-related deaths in 2017, the United States has reached a 20-year high according to the Centers for Disease Control and Prevention (CDC) (4). We, the leadership of 6 of the nation's largest physician professional societies, whose memberships include 731 000 U.S. physicians, reiterate our commitment to finding solutions and call for policies to reduce firearm injuries and deaths. The authors represent the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American College of Surgeons, American Medical Association, and American Psychiatric Association. The American Public Health Association, which is committed to improving the health of the population, joins these 6 physician organizations to articulate the principles and recommendations summarized herein. These recommendations stem largely from the individual positions previously approved by our organizations and ongoing collaborative discussion among our leaders (1, 5–10).

Background

In 2017, a total of 39 773 people died in the United States as a result of firearm-related injury–23 854 (59.98%) were suicides, 14 542 (36.56%) were homicides, 553 (1.39%) were the result of legal intervention, 486 (1.22%) were subsequent to unintentional discharge of a firearm, and 338 (0.85%) were of undetermined origin. The population-adjusted rates of these deaths are among the highest worldwide and are by far the highest among high-income countries (11, 12). Firearm-related deaths now exceed motor vehicle–related deaths in the United States (13, 14). Further, estimates show that the number of nonfatal firearm injuries treated in emergency departments is almost double the number of deaths (15). Firearm-related injury and death also present substantial economic costs to our nation, with total societal cost estimated to be $229 billion in 2015 (16).

While mass shootings account for a small proportion of the nearly 109 firearm-related deaths that occur daily in the United States (11), the escalating frequency of mass shootings and their toll on individuals, families, communities, and society make them a hot spot in this public health crisis. Mass shootings create a sense of vulnerability for everyone, that nowhere–no place of worship, no school, no store, no home, no public gathering place, no place of employment–is safe from becoming the venue of a mass shooting. Mass shootings have mental health consequences not only for victims, but for all in affected communities (17), including emergency responders. Studies also show that mass shootings are associated with increased fear and decreased perceptions of safety in indirectly exposed populations (18, 19). Preventing the toll of mass firearm violence on the well-being of people in U.S. cities and towns demands the full resources of our health care community and our governments.

This article was published at Annals.org on 7 August 2019.

Universal background checks

Funding for research

Intimate Partner Violence

Safe Storage

Access to Mental Health treatment

Extreme Risk Protection Laws

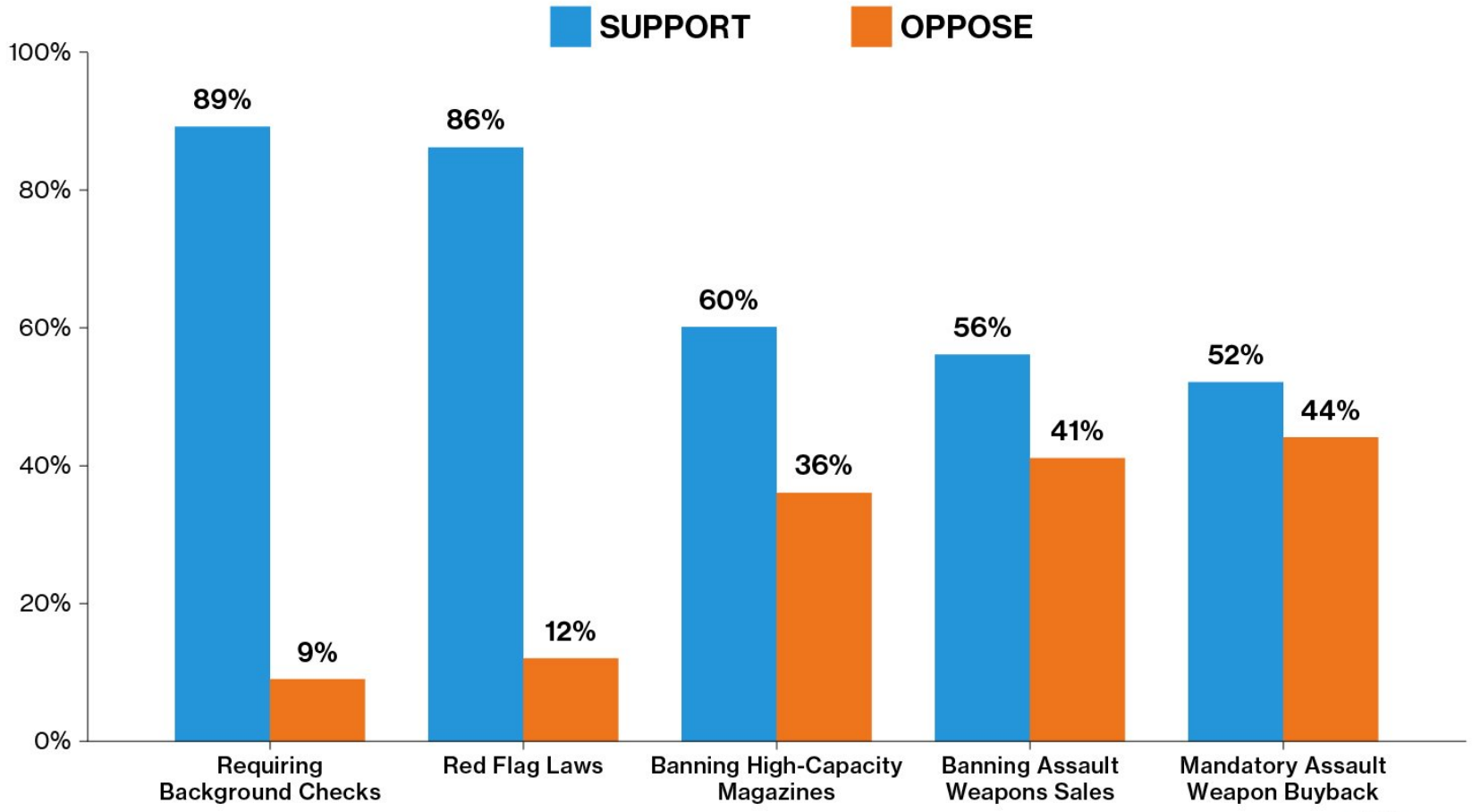
Physician counseling and "Gag Laws"

Firearms with Features designed to increase their rapid and extended killing capacity

We *stand for* policies to reduce firearms-related injuries and deaths.

- Congress should support the following bills to address the public health consequences of firearms:
  - Cosponsor and pass the Gun Violence Prevention Research Act (H.R. 674/S. 184), to provide $50 million for the CDC and other federal agencies to fund research on the prevention of firearms-related injuries and deaths.
  - Senators should follow the action taken by the House and pass the Violence Against Women (VAWA) Reauthorization Act of 2019 (H.R. 1585), to provide protections for domestic violence victims by restricting access to firearms by those deemed a threat to them.
  - Senators should follow the action taken by the House and pass the Bipartisan Background Checks Act of 2019 (H.R. 8), to expand background checks to all firearms sales in the United States.
  - Cosponsor and pass the Assault Weapons Ban of 2019 (S. 66/H.R. 1296), to ban the sale of certain types of semi-automatic rifles and high capacity magazines.

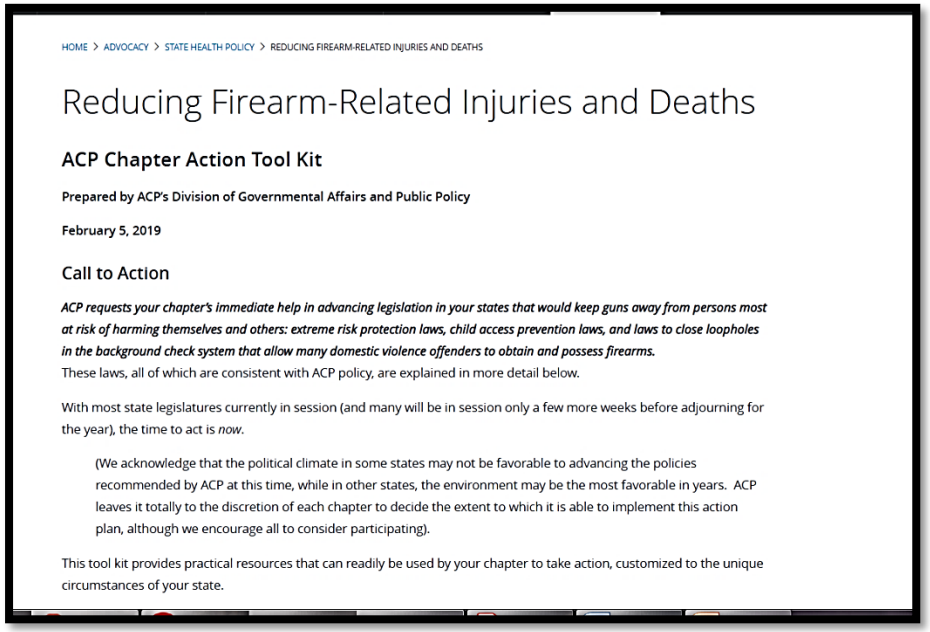
VIEWS ON GUN LEGISLATION



Six in 1o Fear a Mass Shooting; Most Think Gun Laws Would Help, ABC New/Washington Post poll, September 9, 2019 https://www.langerresearch.com/wp-content/uploads/1207a2GunPolicy.pdf

We *are* making a difference.

- Several states have enacted, or are close to enacting, extreme risk protection laws, bans on undetectable guns, universal background checks, and closing domestic violence loopholes. ACP developed a Chapter Tool Kit to help chapters advocate with your own legislators.



HOME > ADVOCACY > STATE HEALTH POLICY > REDUCING FIREARM-RELATED INJURIES AND DEATHS

Reducing Firearm-Related Injuries and Deaths

ACP Chapter Action Tool Kit

Prepared by ACP's Division of Governmental Affairs and Public Policy

February 5, 2019

Call to Action

ACP requests your chapter's immediate help in advancing legislation in your states that would keep guns away from persons most at risk of harming themselves and others: extreme risk protection laws, child access prevention laws, and laws to close loopholes in the background check system that allow many domestic violence offenders to obtain and possess firearms.
These laws, all of which are consistent with ACP policy, are explained in more detail below.

With most state legislatures currently in session (and many will be in session only a few more weeks before adjourning for the year), the time to act is *now*.

(We acknowledge that the political climate in some states may not be favorable to advancing the policies recommended by ACP at this time, while in other states, the environment may be the most favorable in years. ACP leaves it totally to the discretion of each chapter to decide the extent to which it is able to implement this action plan, although we encourage all to consider participating).

This tool kit provides practical resources that can readily be used by your chapter to take action, customized to the unique circumstances of your state.

We stand for ensuring all Americans have access to affordable coverage.

- A Texas judge ruled that the entire ACA is unconstitutional, because the 115th Congress repealed the individual tax penalty for not having coverage, without repealing the coverage requirement itself.
- Instead of defending the ACA, the Trump administration supports the judge's view that the entire law should be struck down. ACP joined with AMA, other organizations urging reversal on appeal.
- If not reversed, the result would be catastrophic:
  - No protections for pre-existing conditions.
  - No essential benefit requirements.
  - Lifetime and annual caps on benefits would return.
  - No premium subsidies to make coverage affordable.
  - No funding for Medicaid expansion.
  - No phasing out of the Medicare Part D doughnut hole.
  - Preventive services no longer would be offered by Medicare at zero out-of-pocket cost.
  - The Center on Medicare and Medicaid Innovation likely would shut down, threatening APMs

We stand for ensuring all Americans have access to affordable coverage.

- New ACP position paper, **Improving the Patient Protection and Affordable Care Act's Insurance Coverage Provisions: A Position Paper From the American College of Physicians** recommends steps to close coverage gaps, including lifting income cap on premium subsidies, reinsurance, and universal Medicaid expansion, public option in all exchanges.
- Congress should support the *Protecting Pre-existing Conditions and Making Health Care More Affordable Act of 2019* (H.R. 1884), which strengthens and expands tax credits; stops skimpy health plans that do not cover essential benefits and discriminate against people with pre-existing conditions; and provides funding for reinsurance programs.

We stand for reforming physician payments to support value of care by internists.

- 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

Previous CMS Proposal:

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	Visit Code Alone*	Visit Code Alone Payment	Visit Code With Either Primary or specialized care add-on code**	Visit Code with New Extended Services Code (Minutes Required to Bill)	Visit with Both Add-on and Extended Services Code Added**	Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

Need for E/M Proposal Changes

- 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!*

Dr. Fox makes to case to the RUC for value of complex cognitive care!

Dr. 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

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

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).

Summary of Changes cont.

- The elimination of History and Exam key components made 99201 and 99202 the same descriptor, so 99201 was deleted.
- A prolonged services add-on code was created. A minimum of 15 minutes is required for each unit of this code.

Summary of Changes cont.

- MDM is based on the **number and complexity of problems addressed**, the amount and/or complexity of **data** to be reviewed and analyzed and the **risk** of complications and/or morbidity or mortality of patient management.

- THERE IS NO REQUIRED MINIMUM TIME (for 99202-99215) as long as your MDM supports the required documentation for the level of service selected.

- Time is an ***option*** for code selection.

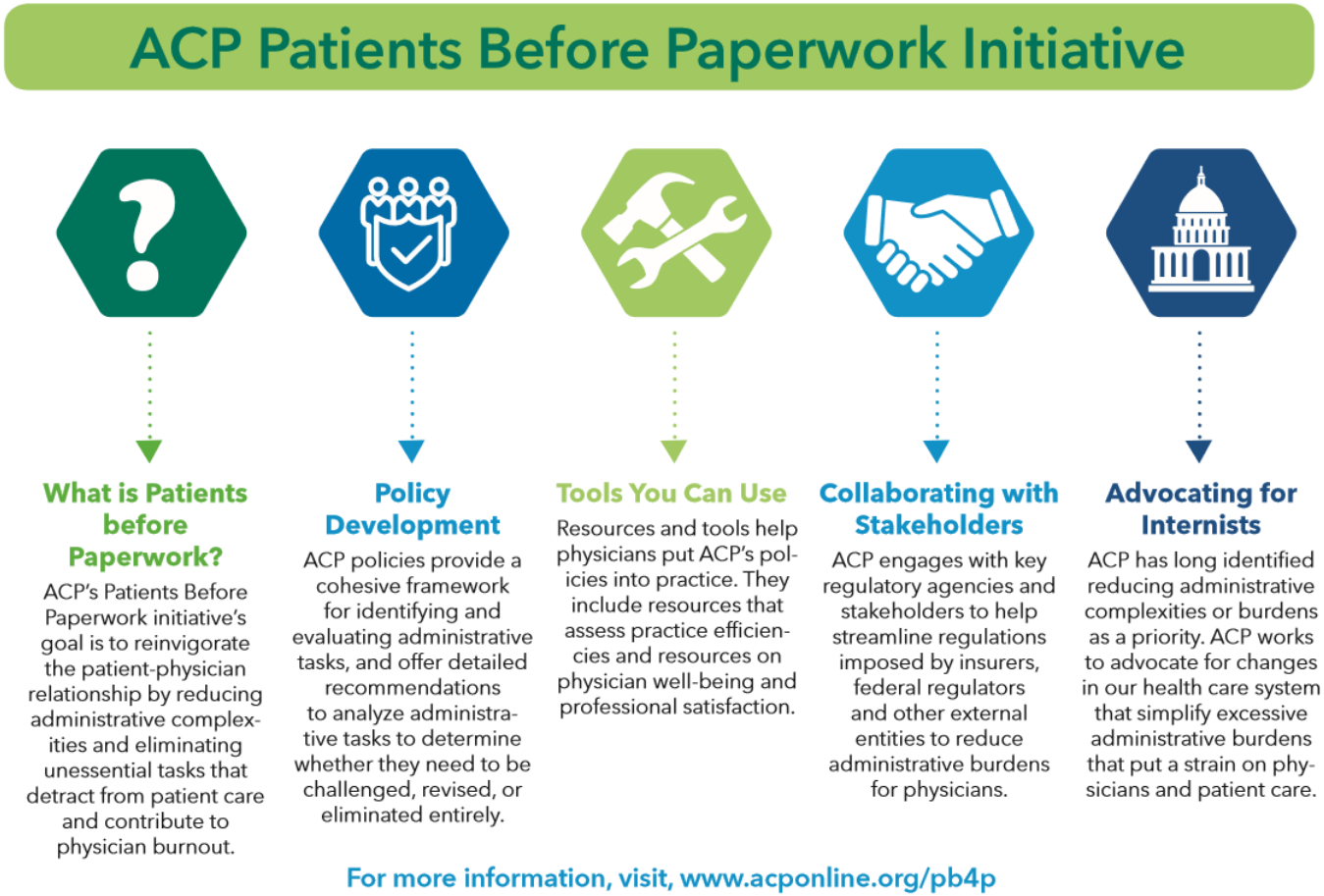
Care Management Services

- Transitional Care Management
  - CMS is proposing to increase the work RVUs for these services.
  - Also considering for separate reimbursement for services that are currently considered overlapping.
- Chronic Care Management
  - CMS proposes to adopt two new G codes with new increments of clinical staff time instead of the existing single CPT code.
    - HCPCS code GCCC1: Chronic care management services, initial 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
    - HCPCS code GCCC2: Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (Use GCCC2 in conjunction with GCCC1).

Care Management Services

- 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.

ACP stands for reducing administrative burdens.



Patients Before Paperwork:

- ✓ Reduce E/M documentation requirements
- ✓ Eliminate/standardize preauthorization
- ✓ Reduce burden of reporting under Medicare Quality Payment Program
- ✓ Fewer, better, more meaningful, relevant and actionable performance measures

We stand for protecting patients from surprise bills.

- *Hold Patients Harmless*: ACP strongly supports legislative efforts to provide protections for patients from unexpected out-of-network health care costs, when additional services are provided by out-of-network clinicians without the patient's prior knowledge.
- *Examine Network Adequacy*: Health plans have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care. Evidence exists that narrow networks contribute to surprise out-of-network costs.
- *Include A Dispute Resolution Process*: ACP supports creating process that would allow an independent arbitrator to establish an appropriate and fair payment level between the insurers' in-network rate and the clinician's charge.

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 560,00 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

Tweet from CMS admin. Seema Verma, pictured with Dr. Lopez and ACP Staff Shari Erickson and Brooke Rockwern

Then ACP-president Dr. López, Group of 6 with Sen. Patty Murray, D-WA

Dr. López and the G of 6 make the rounds on Capitol Hill

Dr. Moyer and G of 6 with Admiral Brett Giroir, assistant secretary of Health at HHS

We're in the room where it happens

Dr. Fox at the RUC

LD attendees with Rep. Ami Bera, D-CA

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

LD day attendees with Senator Bill Cassidy, R-LA

Yet can’t we do more?

- What if we were to craft a comprehensive statement of what changes should be made to American health care, supported by evidence, to better serve the needs of patients and the physicians who care for them?
- And used it to challenge *everyone* involved to make the needed changes?
- Well, this is exactly what *ACP’s New Vision for American Health Care* is all about.

ACP's *New Vision for American Health Care* will better define and communicate what we stand for, and why

- Offer what we hope to achieve, and why, through the public policy recommendations on coverage and cost, payment and delivery system reforms, and improving public health and reducing barriers to care, supported by a review of the evidence.
- Intended audience includes, but is not limited, to our members, legislative and regulatory policymakers, consumers/patients, health plans/payers (CMS and private payers), and industry.
- Timed to be released in early 2020, to influence health care debate preceding 2020 elections and next administration, Congress.

Why do we need to do better?

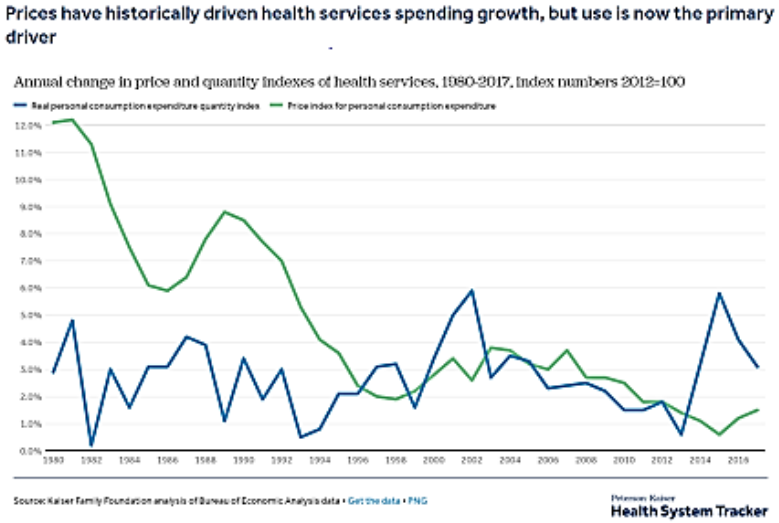
- ACP's evidence review focused on four key questions about U.S. health care:
  - Why do so many American lack coverage for the care they need?
  - Why is U.S. health care so expensive and unaffordable for many?
  - What other barriers do patients face in accessing high quality, equitable, and affordable care?
  - What is the role of delivery and physician payment systems in contributing to higher costs, reduced access, uneven quality and lack of equity?

Lack of coverage

- Despite historic gains in coverage from the Affordable Care Act (ACA), the U.S. remains the lone high-income industrialized nation without universal health coverage, which can be defined as a system that ensures everyone can access quality health care without being subject to substantial financial burden.
- Affordability is among the most commonly cited reason for remaining uninsured.

Higher spending

- The nation spends far more per-capita on health care compared to other wealthy countries and in 2016, nearly 18% of the nation's gross domestic product was directed to health care. Price has been and continues to be the main driver of high health care spending in the U.S.



“It’s the prices, stupid.”

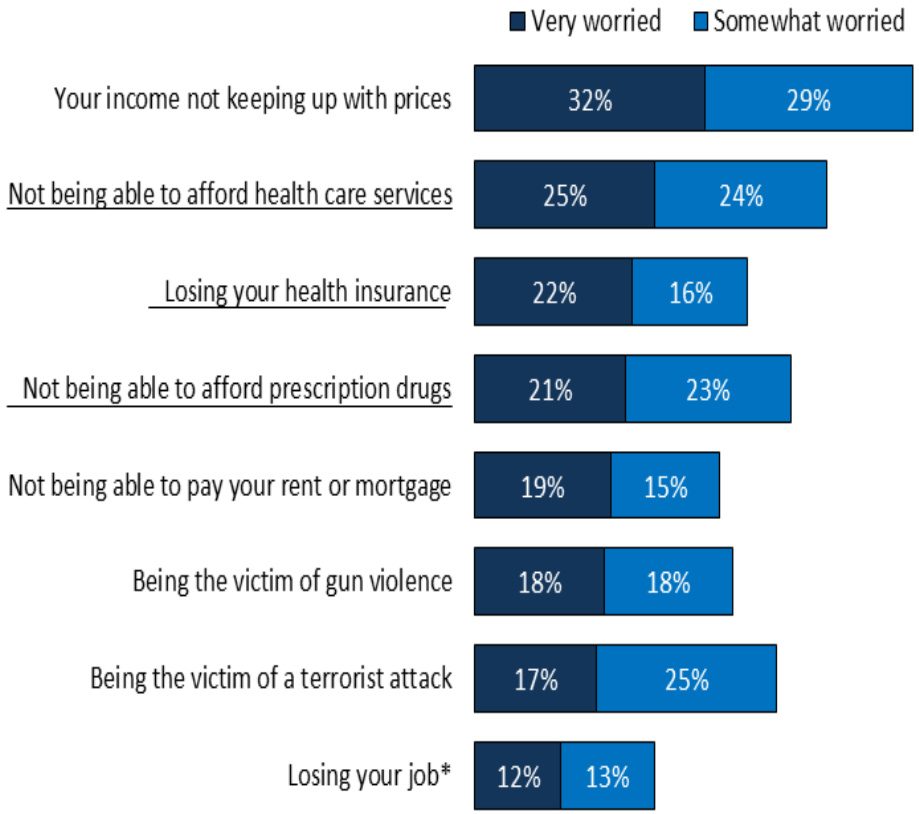
“The United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries.”

Papanicolos, Irene, et al. Health Care Spending in the United States and Other High-Income Countries, Journal of the American Medical Association, March 13, 2018. Accessed at: https://jamanetwork.com/journals/jama/article-abstract/2674671

Figure 6

Cost Concerns, Including Health Care Costs, Top List of Worries

Percent who say they are worried about each of the following:



NOTE: "Losing your health insurance" was asked among those who were insured and "Losing your job" was asked among those who were employed. Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)

THE HENRY J. KAISER FAMILY FOUNDATION

A family of four with a $100,000 income and employer coverage spends $12,500 per year (13% of their income) on health.

By Cynthia Cox

HHSC Charts |
Posted: September 11, 2018

SHARE

Direct Spending on Healthcare

A **family of four** with a **$100,000** income and **employer** coverage spends **$12,500** per year (**13%** of their income) on health. This includes **$2,900** (**3%** of their income) in out-of-pocket health spending, **$4,550** (**5%** of their income) in health insurance premiums, and approximately **$5,050** (**5%** of their income) in state and federal taxes that fund health programs.

Additional Contributions by Employers

Workers are not taxed on the contributions their employers make toward health insurance premiums. Economists generally believe that employer contributions offset wages. In this scenario, we estimate that the employer is contributing an additional **$13,050** to health insurance premiums, as well as **$1,450** in Medicare payroll taxes. These amounts are not shown in the chart above, but economists generally believe that they offset wages.

When combined, this family's spending on health care and the money spent by their employer on their behalf totals **$27,000.**

Higher administrative costs

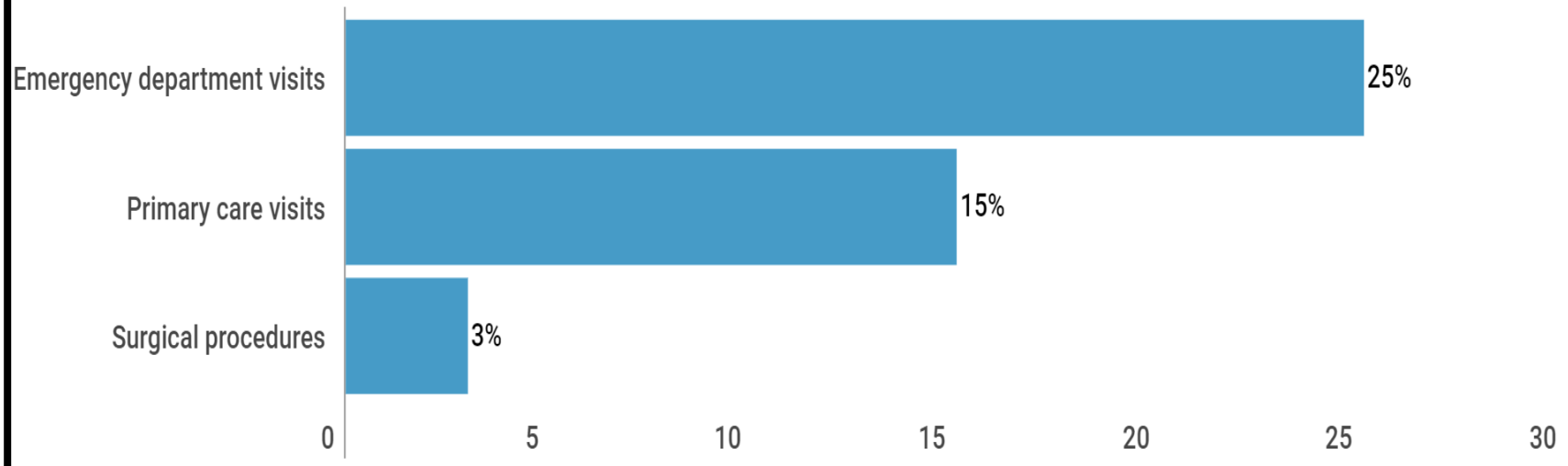
- Administrative costs account for 8% of total U.S. health care spending and include a myriad of services from billing and insurance related activities to quality improvement programs.
- Complex medical billing and documentation requirements, quality reporting requirements for value-based payment initiatives, and other administrative tasks have made the United States health care system one of the most, administratively burdensome in the world, contributing to less time treating patients, billions in unnecessary administrative costs, and unprecedented levels of physician burnout and dissatisfaction.

80%

of billing-related costs are a result of our multi-payer US health system

Jiwani, Aliya, et al. "Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence." *BMC Health Services Research.* 2014.

Percent of total revenue spent on billing-related costs



Tseng, Phillip, et al. "Administrative costs associated with physician billing and insurance-related activities at an academic health care system." *JAMA.* 2018.

Uneven and inequitable outcomes

- While the health care system of the United States excels in some areas, such as decent care process outcomes, it consistently ranks last or near-last in access, administrative efficiency, equity, and health care outcomes.
- Life expectancy has been decreasing in the United States since 2014, and ranks last when compared to other high income developed countries at 78.9 years.
- Environmental health hazards, poor nutrition, tobacco use, prescription drug abuse, firearm violence, and maternal mortality – are reversing progress made over generations of increasing life expectancy.

New Vision framework (subject to change)

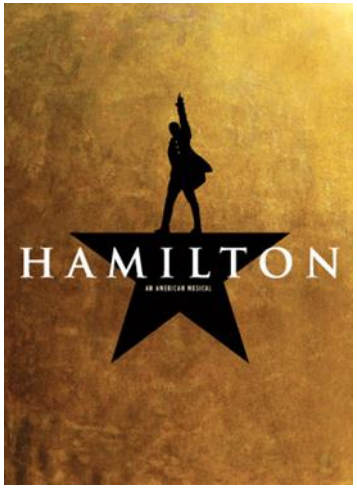
- Four papers:
  - Call to action on what ACP envisions a better health care system for all would look like and a call for others to join us.
  - Three companion policy papers on *coverage and cost*, *payment and delivery system reforms*, and *improving public health and reducing barriers to care*

The 3 companion papers will propose specific policies to:

- Achieve universal coverage at a cost the country and the patient can afford—including lowering costs at the system-level (slow rate of increase, reduce per capita spending), and making care more affordable at the patient-physician level (affordablility).
- Address excessive spending on health care administration and associated burdens on physicians and patients.
- Reform payment and delivery system with an emphasis on supporting primary care and specifically the value of care provided by internal medicines specialists.
- Propose specific policies to improve public health, address social determinants, and end disparities and discrimination based on personal characteristics.

Hamilton:

And I wanted what I got
When you got skin in the game, you stay in the game
But you don't get a win unless you play in the game
Oh, you get love for it, you get hate for it
You get nothing if you
Wait for it, wait for it, wait
God help and forgive me
I wanna build
Something that's gonna
Outlive me



"I wanna build something that's gonna outlive me."

By standing for *something*, and *knowing how the sausage is made*, ACP is in the room where it happens.

Our New Vision initiative gives us a chance to help build a better health care system for generations to come.