How to build a coalition, lessons learned as a clinician activist

John D. Goodson MD, FACP
Physician
Massachusetts General Hospital
Associate Professor of Medicine
Harvard Medical School
The stages of activism

• Pre-contemplation: I accept what is… but I am unsettled. Why is the world like it is?
• Contemplation: Do I want to get involved?
• Preparation: Who can I turn to? What do I need to know?
• Change: Where can I make a difference? What are the leverage points? How can I create an “inflection?”
• Maintenance: Find your successors, “Watch one, do one, teach one.”
My themes

1. Understand why the world is as you have encountered it, history matters.
2. Moments of awakening appear unexpectedly, be prepared to answer the call.
3. Activism demands knowledge, know your resources and/or develop your own data.
4. Coalition building depends on valued added, your value and the value of others.
Medicare A vs. B: 80% of the “Usual and Customary”

Medicare A: Hospital care
- DRG payments based on diagnosis and risk adjusters
  - $914,000,000,000
    - $731,000,000,000 Feds
    - $183,000,000,000 Patients/Supplements

Medicare B: Professional services (MD + "Eligible Providers")
- $91,000,000,000
  - $73,000,000,000 Feds
  - $14,000,000,000 Patients/Supplements
The power of legislative language: Omnibus Budget Reconciliation 1988

“Provides for the gradual transition, from 1992 through 1995, to the determination of Medicare payments for physician services pursuant to a fee schedule which takes into account the relative value of the work, practice expenses, and malpractice risks associated with each physician service…."

“Provides for the gradual transition, from 1992 through 1995, to the determination of Medicare payments for physician services pursuant to a fee schedule which takes into account the relative value of the work, practice expenses, and malpractice risks associated with each physician service....”

Thus began the Physician Fee Schedule (PFS) based on the Resources-based Relative Value Scale (RBRVS)
CMS FFS Pricing: Medicare’s Physician Fee Schedule (PFS)

On January 1 each year, the Center for Medicare and Medicaid Services (CMS) issues a **physician fee schedule** (PFS).

The valuation (i.e. pricing) for each service is provided in **RVUs (relative value units)**.

Payment is calculated by multiplying the total relative value units times **conversion factor, roughly $36**.

Commercial carriers and all others (DOD, VA, Medicaid) use the same pricing with percentages up or down.
Welcome to our world: The land of RVUs

“The devil of the details”
Let’s talk about coding: Kreb’s vs. RBRVS
(Resource-based Relative Value Scale)
Basic terminology

*What we do:* **CPT** (Current Procedural Terminology): What we do, descriptions of services. Proprietary to the AMA. 2000, Congress establishes as the “source code.”

*Why we do it:* **ICD** (International Classification of Diseases): The diagnostic code assigned to each disease or condition, ICD 10

*We are paid in RVUs* (Relative Value Units, the “coin of the realm”) for each CMS service with an RVU value
What are the PFS service codes used in internal medicine?

E/M (Evaluation and Management, N = 100) are the codes used by all physicians for the non-procedural service.

For outpatient IM, we use the outpatient new patients (99202-5) and established patient (99212-5) codes.

Procedural codes (N = 10,000) are used for virtually all procedures.
All models of care delivery use RBRVS building blocks to calculate the work done

- Salary models use the PFS to establish productivity goals/bonus thresholds.
- PCMH compensation models derived from the services delivered by each clinician based on the PFS
- ACO revenue distribution AND resource allocation derived from the relative values assigned to the work done
The origins of service:

Let’s begin at the beginning

The journey to the land of RBRVS:
The road to the RBRVS:
Step 1: Crisis of sustainability

1980s: Medicare payment crisis from “usual and customary” payments, Congress reacts

1985: HCFA (CMS) begins RBRVS study. CPT 4 has 7000 codes (6900 are for procedures)

1987-89: Hsiao study and his assumptions:
- Payment for work and costs
- Intensity = technical skill + mental/physical effort + psychological stress (not time!)
- Time intervals: Pre, intra and post-service
1988: The Harvard Report,
Hsiao and Braun: The RBRVS “tablets”

A NATIONAL STUDY OF RESOURCE-BASED
RELATIVE VALUE SCALES FOR PHYSICIAN SERVICES
FINAL REPORT

by William C. Hsiao, Ph.D.
Peter Braun, M.D.
Edmund Becker, Ph.D.
Nancyanne Causino, Ed.D.
Nathan P. Couch, M.D.
Margaret DeNicola, R.N., M.P.H.
Daniel Dunn, Ph.D.
Nancy L. Kelly, Ph.D.
Thomas Ketcham, M.P.H.
Arthur Sobol, M.A.
Diana Verrilli, B.A.
Douwe B. Yntema, Ph.D.

Federal Project Officer: Jack Langenbrunner

Department of Health Policy and Management
Harvard School of Public Health
and the Department of Psychology,
Harvard University (Dr. Yntema)

HCFA Contract No. 17-C-98795/1-03
September 27, 1988
The road to RBRVS:  
Step 2: Research to policy

1987-89: Hsiao study
Payment = (Work)(1 + Practice Costs)(1 + Opportunity Costs)

1986-89: Congressional Physician Payment Review Commission (PPRC, later to become MedPAC)
Payment = Work + Practice Expense + Malpractice

1991: AMA forms the Relative-value Update Committee (RUC)
“to make recommendations to CMS on the relative values to be assigned to new or established codes…”

1992: Resource-based relative value scale (RBRVS)
The RBRVS establishes the pricing within “monetary system” of health care payment

Resource-based relative value scale (RBRVS)
• Weighted system (Geographically)
• Assigns worth = “RVUs” to each CPT code
• 3 components: Total RVUs = W + P + M
  – Work “…Clinical work…” (52%)
  – Practice Expense “overhead” (44%)
  – Malpractice “liability insurance” (4%)
Physician payment since 1992

Payment =

\[ ((RVU_w \times GPCI_w) + (RVU_p \times GPCI_p) + (RVU_m \times GPCI_m)) \times CF \]

= [Total RVUs] \times CF

RVUs = “coin of the realm”

1 RVU = $36.09 in 2020
Some critical assumptions in RBRVS

**Bundling:** Payments made for the pre visit, face to face, and post visit work of each encounter = pre-, intra- and post-service times. For a 99214:

- Pre visit = 5 minutes
- Intra visit = 25 minutes
- Post visit = 10 minutes

**Global payments:** Payments made for the projected average care experience for a given service (zero, 10 days, 90 days).
## Common outpatient E&M wRVUs

<table>
<thead>
<tr>
<th>New</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202 - 0.93</td>
<td>99212 - 0.48</td>
</tr>
<tr>
<td>99203 - 1.42</td>
<td>99213 - 0.97</td>
</tr>
<tr>
<td>99204 - 2.43</td>
<td>99214 - 1.50</td>
</tr>
<tr>
<td>99205 - 3.17</td>
<td>99215 - 2.11</td>
</tr>
</tbody>
</table>

99214 Total non facility RVUs =

\[
1.50 + 1.53 \text{ (PE)} + 0.10 \text{ (M)} = 3.13 \text{ RVUs} = $113 \quad (2020\text{CF} = $36.09)\]
So what has happened since 1992?

Expansion of complexity/ intensity of cognitive care
  --Combination therapies
  --More ambitious treatment goals (P4P)
  --Shifting demographics
  --Disease prevention/health promotion agenda

New procedures
  --Interventionalism

Improved efficiencies
  --Surgicenters
The relative values of physician services have trended in the opposite direction

<table>
<thead>
<tr>
<th></th>
<th>Total time</th>
<th>RVUs</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established OP E/M, 99214</td>
<td>35</td>
<td>1.50</td>
<td>$54</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>24</td>
<td>3.69</td>
<td>$133</td>
</tr>
<tr>
<td>Cataract extraction and lens implantation</td>
<td>23.5</td>
<td>10.36</td>
<td>$373</td>
</tr>
</tbody>
</table>
### The wide range of MD payments

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>General family practice</td>
<td>$235,000-$267,000</td>
</tr>
<tr>
<td>General internal medicine</td>
<td>$255,000-$279,000</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$221,000-$264,000</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$392,000-$519,000</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$405,000-$530,000</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>$501,000-$679,000</td>
</tr>
<tr>
<td>Diagnostic radiology</td>
<td>$371,000-$517,000</td>
</tr>
<tr>
<td>Dermatology</td>
<td>$371,000-$492,000</td>
</tr>
</tbody>
</table>

Source: Merritthawkins.com 2018
Resident interest in OP GIM has plummeted!

The proportion of third year residents in GIM is falling:

Woo, N Engl J Med 2006;355;
The bundled RVUs with 10 and 90 day global procedural payments are not provided.

RAND study, 2019 of global Services delivered:
-96% if 10-day do no occur
-63% of 90-day do not occur

Removal of these undelivered services reduces procedure payment 60-70%!!

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html
## What are the alternatives?

<table>
<thead>
<tr>
<th></th>
<th>FFS</th>
<th>FFS + Quality</th>
<th>Capitation +Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td>Have the power of choice</td>
<td>Low payment services scarce</td>
<td>Health is the endpoint</td>
</tr>
<tr>
<td>Physicians</td>
<td>Payment for work done</td>
<td>Incentive to do too much</td>
<td>Focus on the key endpoints</td>
</tr>
<tr>
<td>Costs</td>
<td>Pay for what is done</td>
<td>Too many high cost procedures</td>
<td>Payment for outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Priority on population health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Diversion of resources to metrics</td>
</tr>
<tr>
<td><strong>Cons</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td>Low payment services scarce</td>
<td>Health is the endpoint</td>
<td>Care distracted by metrics</td>
</tr>
<tr>
<td>Physicians</td>
<td>Incentive to do too much</td>
<td>Focus on the key endpoints</td>
<td>Measures not credible</td>
</tr>
<tr>
<td>Costs</td>
<td>Too many high cost procedures</td>
<td>Payment for outcomes</td>
<td>Resources diverted to metrics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Population health priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Individual needs subsumed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Corporate life</td>
</tr>
</tbody>
</table>

- **FFS**
  - Pros: Have the power of choice
  - Cons: Low payment services scarce

- **FFS + Quality**
  - Pros: Health is the endpoint
  - Cons: Care distracted by metrics

- **Capitation +Quality**
  - Pros: Population health priority
  - Cons: Individual needs subsumed
# What are the alternatives?

<table>
<thead>
<tr>
<th>“Value-based” payments</th>
<th>FFS + Quality Capitation +Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
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<td><strong>Costs</strong></td>
<td>Pay for what is done</td>
</tr>
</tbody>
</table>
Health care costs will “bend”

- Incentives for “quality” will improve the “value” of health care expenditures
- Incentives must be for more than “nominal risk”
MACRA Payment Options

QPP (Quality Payment Program, formerly MIPS, Merit-based Incentive Payment System)  APMs (Alternative Payment Models)
Quality Payment Program (QPP) penalties and APM incentives

<table>
<thead>
<tr>
<th>Year</th>
<th>QPP Adjustments</th>
<th>APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>+/- 4%</td>
<td>+/- 5%</td>
</tr>
<tr>
<td>2020</td>
<td>+/- 5%</td>
<td>+/- 7%</td>
</tr>
<tr>
<td>2021</td>
<td>+/- 7%</td>
<td>+/- 9%</td>
</tr>
<tr>
<td>2022</td>
<td>+/- 9%</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>+/- 9%</td>
<td></td>
</tr>
</tbody>
</table>
How will EPs (Eligible Providers) be scored under QPP?

QPP Composite Performance Score (CPS) 0-100

Quality: 30-60
Cost: 0-30
Clinical practice improvement activities (CPI): 15
Advancing Care Information (ACI): 25

0-100 Points
≤ 25 points is penalty threshold

Timeline for your QPP/MIPS Composite Practice Scores (CPS)

- Cost
- Quality
- Practice Improvement
- EHRs

Timeline:
- 1/1/2019
- 1/1/2020
- 1/1/2021
- 1/1/2022
- 1/1/2023
- 1/1/2024
MACRA: The critical unknowns?

- **Patient attribution**: How will MDs know which patients they are accountable for? Attribution will begin retrospectively. Will patients accept prospective attribution?

- **Quality Measures**: Will measures be relevant and actionable?

- **Risk adjustment**: Will risk adjustment tools be adequate?
  - Can HCC (Hierarchical Condition Category) risk adjustment account for individual patient panels?
  - Dual eligibly is based on state-by-state Medicaid standards
Alternative Payment Models (APMs) Enterprises, specialty collaboratives, etc.

- Eligible APMs
  - Quality measures comparable to those in MIPS
  - Certified EHR technology

- Risk defined:
  - Bear more than “nominal” financial risk for monetary losses OR
  - Be a medical home model
The physician fee schedule is the Achilles’ heel of MACRA

“Implementing new incentives and quality measures in new payment models while maintaining broken fee schedule is a prescription for failure.”

Goodson and Berenson
Pre-Contemplation:
I accept what is...but I am unsettled.
Why is the world like it is?
How did we get into this predicament?

Bill Hsiao knew that primary care and other cognitively intense work was not properly valued from the beginning of the RBRVS.

Hsiao (1988): “Important research needs to be done including…Developing a more suitable extrapolation method for E/M services…to address the ambiguity in the …descriptions of these services.”
Contemplation:
Do I want to get involved?
How the RVRVS was to be updated: The Five-year Reviews

- Mandated in statute
- Opportunity to make corrections in the RBRVS
  - Correct anomalies
  - Adjust “relative values”
  - Introduce new codes
The Third Five Year Review of the Evaluation/Management (E/M) codes 2005-2007: The immersive experience

- Established outpatient level 4 (99214) was valued at 1.1 wRVUs.
- Coalition formed of 27 cognitive-based organizations, by ACP, AAFP. SGIM invited due to membership in ACP committee, Sub-specialty Advisory Group on Socioeconomic Affairs (SAGSA)
E/M review: Survey to RUC workgroup

- Survey development based on clinical vignettes, codes of interest drafted by SGIM, severely truncated by surgeons.
- Data analysis, June-July 2005
- Strategic planning, July 2005
- RUC Workgroup presentation, August 2005
- Recommended 99214 be increased to 1.5 wRVUs
E/M review: Workgroup to RUC

• RUC workgroup, August 2005
  –ASC: “There has been no change in the cognitive content of internal medicine in 10 years.”

• RUC, September 2005
  –Failure to reach consensus on codes of interest, 99213-99215
  –Politics of filibuster: Coalition of 10/27 RUC members became 18/27 by refusing to budge from 1.50 RVUs for 99214.

• RUC resolution, February 2006

26 months
12% of practicing MDs

The AMA's Franchise:
Relative-value Update Committee (RUC), 1991

$130,000,000/yr.
How are services defined and valued?

Professional Society

AMA’s CPT Editorial Panel

AMA’s RUC Level of interest

AMA’s RUC Survey

Specialty AMA’s RUC “Work Group”

Medicare’s Physician Fee Schedule

90% acceptance by CMS 1992–2010

2/3 vote required

The AMA’s RUC
Who is on the AMA’s RUC?
MD composition strongly favors specialists, 20/25

Primary Care (6):
- Emergency medicine
- Family medicine
- Geriatrics
- Internal medicine
- Pediatrics
- Primary care**

Non PC specialists (5):
- Psychiatry
- Neurology
- BM transplant**
- Cardiology
- Renal**

Proceduralists (14):
- Anesthesia
- Dermatology
- ENT
- General surgery
- GI surgery**
- Neurosurgery
- OB/GYN
- Orthopedic surgery
- Ophthalmology
- Pathology
- Plastic surgery
- Radiology
- Thoracic surgery
- Urology

**Rotating seats
Preparation:
What do I need to know?
**Unintended Consequences of Resource-Based Relative Value Scale Reimbursement**

John D. Goodson, MD

Terol levels were managed actively. Targets for secondary prevention decreased with successive clinical studies, and

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**The Undervaluation of Evaluation and Management Professional Services**

The Lasting Impact of Current Procedural Terminology Code Deficiencies on Physician Payment

Erik A. Kemetz, MA; and John D. Goodson, MD

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**SGIM White Paper: The case for the redefinition and reevaluation of the outpatient Evaluation and Management (E&M) service codes and the development of new documentation expectations**

May 2015

Atul Nakhasi and John Goodson, MD

Endorsed by the SGIM Council July 10, 2015
The growing interest in reforming the fee schedule

• **MedPAC**: “The Commission remains concerned within Medicare’s fee schedule for the services of physicians…primary care remains undervalued…” (2014)

• **Urban Institute** (December, 2016): “We suggest that CMS shift from its current approach common, which relies on specialty societies surveys and the RUC…, to empirical determination of time.”

• **Fixing Medical Prices**. Miriam Laugesen (Harvard Press, 2016)
CMS Responds: Primary Care Codes

Primary care compensation and the art of cobbling
CMS and Primary Care Payment

- E/M, 99201-5, 99211-5
- IPPE, 2005
- AWVs, 2011 (ACA)
- TCMs, 2013 (CMS)
- CCM, 2015, 2017 (CMS)
- Prolonged Service
Change: Where can I make a difference?
What are the leverage points?
How can I create an “inflection?”
Finding new best friends for primary care: Aligning with other “cognates”

February 2015: SGIM open call for representatives of cognate specialty societies
March 2015: Agreement on principles
Meeting with CMS leadership in DC
Meetings with Congressional staff
Discussion with MedPAC
March 23, 2015

Mr. Sean Cavanaugh  
Deputy Administrator and Director  
Center for Medicare  
Centers for Medicare and Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Proposal to redefine and revalue outpatient Evaluation and Management (E&M) service codes

Dear Mr. Cavanaugh:

The undersigned specialty societies request that the Centers for Medicare and Medicaid Services (CMS) engage in a process to create additional outpatient evaluation and management (E&M) codes. We believe that the existing office codes (CPT 99201-5 and 9921-5) no longer accurately or adequately reflect the work currently provided to and required by Medicare beneficiaries.
The coalition signees

American Academy of Allergy, Asthma and Immunology
American Academy of Family Physicians
American Academy of Neurology
American College of Allergy, Asthma and Immunology
American College of Rheumatology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy
American Society of Hematology
American Psychiatric Association
Endocrine Society
Joint Council of Allergy Asthma and Immunology
Society of General Internal Medicine
“...we recognize that these E/M codes may not reflect all the services and resources involved with furnishing certain kinds of care, particularly comprehensive, coordinated, care management for certain categories of beneficiaries.”
Organizing the resistance:
The Cognitive Care Alliance, CCA

September, 2015: Formation of the Cognitive Care Alliance, CCA

- SGIM as founding member
- Governance
  - Chair: John Goodson
  - Executive director: Erika Miller
  - Executive board: SGIM, ASH, ACR
• SGIM (Founder)
• American Association for the Study of Liver Diseases
• American College of Rheumatology
• American Gastroenterology Association
• American Society of Hematology
• Coalition of State Rheumatology Organizations
• Infectious Diseases Society of America
• The Endocrine Society
The CCA strategy: Evidence-based payment policy

Step 1: Research to define the content of new and established patient evaluation and management (E/M) services

Step 2: Rework valuations
  --More balanced gradations
  --Appropriate valuations
  --Improved documentation requirements
CCA activities

- July 2017: CCA Hill Day
- September 2017: Brookings, URBAN, USC Schaeffer Conference in DC, “The Medicare physician fee schedule and alternative payment models”
  - 22 speakers
- September 2017: Letter to House Labor, HHS, Education and Related Agencies
- October 2017: CCA letter to HHS Assistant Secretary for Strategic Planning
- November 2017: ACP Subspecialty Advisory Group on Socioeconomic Affairs, SAGSA
“The existing E/M codes fail to adequately describe the work demanded by cognitive medical practice and have not maintained their relative valuation with respect to other physician services within Medicare’s physician fee schedule (PFS). These deficiencies are creating workforce shortages and burdening Medicare beneficiaries.”
CCA activities

- December 2017: CCA conference call
- December 2017: Hill Day and CMS meetings in DC
  - Jeet Guram, Sr Advisor to the Administrator, CMS
- December 2017: Families USA in DC
- January 2018: Hill Day and CMS in DC
- February 2018: President’s budget (2018-19) $5M. “This proposal targets CMS’s approach to valuing RVUs in the PFS…”
CCA Activities

- February 2018: CCA sign on letter to HHS and CMS
- February 2018: CCA conference call
- March 2018: SGIM Hill Day
- March 2018: CMS in DC
  - Demetrios Kouzoukas, CMS MD payment team
- April 2018: SGIM National Meeting
- May 2018: Ad hoc meeting in DC
  - Experts and interested parties
2016-18: Payment in the time of disruptive thinking

July 2018: CMS releases proposed payment 2019 policies for public comment

- Reduction of administrative burden: Reduce documentation expectations to level 2 and time for outpatient E/M services
- Collapse payments to two levels
Winners: Dermatology and orthopedics
Losers: Family Medicine, Internal Medicine, Endocrinology, Infectious Diseases
“However, potential unintended consequences and persistent incentives or needs for documentation may blunt the impact of the proposed policy and render it undesirable for patients and providers.”

--Song and Goodson
2018-2019: The AMA’s CPT and RUC respond to the threat to their authority

Jan-Feb 2019: The AMA’s CPT redefines the outpatient E/M codes
March 2019: RUC survey, 1600 responses, < 1%
April 2019: New RUC values for outpatient E/M
July 2019: CMS “Proposed Rule,” payment changes for 2021
November 2019: “Final Rule”
2019: The AMA’s CPT and RUC respond to the threat to their authority

Jan-Feb 2019: The AMA’s CPT redefines the outpatient E/M codes

March 2019: RUC survey, 1600 responses, < 1%

April 2019: New RUC values for outpatient E/M

July 2019: CMS “Proposed Rule,” payment changes for 2020

AMA at warp speed 6 months
HEALTH POLICY

E/M CODING UPDATES: WHAT HAS CHANGED FOR 2020 AND WHAT IS SLATED TO CHANGE IN 2021

John D. Goodson, MD; Erika Miller, JD

Dr. Goodson (jgoodson1@mgh.harvard.edu) is an associate professor of medicine at Harvard Medical School and the Massachusetts General Hospital and is chair of the Cognitve Care Alliance. Ms. Miller (emiller@dc-crd.com) is the executive director of the Cognitve Care Alliance and is senior vice president and counsel at Cavarocchi Ruscio Dennis Associates, LLC, a Washington-based government relations firm.
Planned changes to E/M code documentation expectations for 2021

• **Documentation**
  
  Medical Decision Making only (no more history or PE expectations)

• **Time**
  
  Total time for all work on the date of service, all activities
The complexity add-on for Primary Care

- 99215: 48% increase
- 99214: 50% increase
- 99213: 68% increase
In summary, we urge CMS to maintain the current E/M values for the office visit E/M codes. We suggest that the RUC conduct a survey after physicians and coders have had at least one year of experience with the new codes in order for the RUC to collect more accurate data from providers who have actually used the new coding paradigm. This delay will also provide valuable
The CCA and new friends

September 18, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies as published by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register, August 14, 2019.
Proposal to Form an Expert Panel to Review Evaluation and Management Services

Request:

The Cognitive Care Alliance (CCA), representing over 70,000 physicians from eight cognitively focused specialty societies, proposes that the Centers for Medicare & Medicaid Services (CMS) convene an expert panel to develop recommendations on how to appropriately define, document, and value evaluation and management (E/M) services.
We ask that Medicare immediately remove any barriers prohibiting the outpatient E/M services from being billed for telephone only visits when a video connection cannot be established. The current requirement for simultaneous video and audio connections for the outpatient E/M codes to be delivered via telehealth cannot always be met when patients require outpatient E/M care. Our members have encountered a number of factors that prevent successful simultaneous audio and video connections with their patients:
<table>
<thead>
<tr>
<th>Time</th>
<th>Work RVUs</th>
<th>Total Facility RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established outpatient (Audio+Video)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office of the Secretary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99212</td>
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<tr>
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<td>99443</td>
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The stages of activism: Where are you?

• Pre-contemplation: What have you encountered that seems wrong?
• Contemplation: Do I want to get involved, am I prepared? How well do you understand how this has happened?
• Preparation: What do I need to know?
• Change: Where can I make a difference? What are the leverage points? How can I create an “inflection?”
• Maintenance: Can you explain what you are doing and why you are doing it? “Watch one, do one, teach one!”
Where are you on the path to effective activism?

Thank you!