



WASHINGTON WATCHLINE

PHYSICIAN ADVOCACY FOR EXCELLENCE IN THE DELIVERY OF PULMONARY, CRITICAL CARE AND SLEEP MEDICINE

April 2020

www.namdcrc.org

VOLUME 30 No. 04

A 40 Year NAMDCRC Perspective

As most readers must be aware the NAMDCRC Board of Directors has recommended, and the membership is voting to approve a merger with CHEST. The National Association for Medical Direction of Respiratory Care was established in 1978 by a group of pulmonary physicians who saw a need for an organization that could bring structure to the rapidly evolving field of clinical pulmonary medicine. The physician founders of the organization included Ken Moser, MD, Richard Browning, MD, Louis W. Burgher, MD, PhD, William Burgin, Jr., MD, Ramon Figueroa-Lebron, MD, Jack Kamen, MD, Leroy Misuraca, MD, Neil Schachter, MD, DuWayne Schmidt, MD, Richard Krumholz, MD, Alan L. Plummer, MD, Neil R. MacIntyre, MD and Walter O'Donohue, MD. The Founding President was George G. Burton, MD. Shortly after its formation, the Board of Directors engaged Mr. Philip Porte as the Executive Director.

The 1970s were interesting times in the field of respiratory medicine. Mechanical ventilation had moved from the iron lung of the 1950s to the use of positive pressure ventilation in newly developed respiratory intensive care units. Pulmonary function testing equipment was increasingly sophisticated, portable and affordable. With the increased respiratory support options, the benefit of a trained respiratory therapy staff was becoming apparent. Community hospitals were quickly following in the path of university centers and opening respiratory intensive care units, pulmonary function laboratories and respiratory therapy departments. The founding group set out to recruit clinical pulmonologists and convince hospital administrators that it was in their best interest to appoint board certified physicians as directors of their pulmonary services. To assist physicians, particularly those in community practices, the group published the *Respiratory Medical Directors Handbook*. The Handbook brought together information scattered through the literature of many organizations and agencies involved in the relatively new field of respiratory care. It defined what it meant to be a medical director and what practical issues a physician involved in this field had to address and master to survive.

The WASHINGTON WATCHLINE is published monthly and provides timely information to NAMDCRC members on pending legislative and regulatory issues that impact directly on the practice of pulmonary medicine.

NAMDCRC's primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

INSIDE THIS ISSUE

About NAMDCRC.....	6
Membership Benefits.....	6
NAMDCRC Leadership.....	4
Product and Technology News.....	5

NAMDCRC
8618 Westwood Center Drive, Suite 210
Vienna, VA 22182-2273
Phone: 703-752-4359
Fax: 703-752-4360
Email: ExecOffice@namdcrc.org

"NAMDCRC will directly affect your practice more than any other organization to which you belong."

The rapid expansion of options in the care of patients with respiratory insufficiency and respiratory failure, coincided with government concerns regarding the increasing cost to federal and state programs. It quickly became apparent that there was a need for NAMDRC to address regulatory, legislative and payment issues that related to the delivery of care to patients with respiratory disorders. The founding group promptly established a relationship with the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services (CMS), to address a wide range of issues related to pulmonary medicine. The organization worked with Administration staff to develop Diagnosis Related Groups for acute long term ventilator patients and worked to educate the staff on the clinical intricacies of home oxygen therapy. In addition to developing an advocacy profile based on peer reviewed clinical science, the organization established an Annual Meeting founded on the principle of open communication among membership, healthcare policy makers and the medical industry as well as a monthly publication, *The Washington Watchline*. The purpose of the *Washington Watchline* has been to anticipate changes in the practice environment, created by shifting rules and regulations, and keep the membership informed.

Legislation and CMS

Since the founding of NAMDRC, federal legislation and the subsequent rules and regulations established by CMS staff have had a transformative impact on the health care system. The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) reformed the way Medicare paid for physician services. This legislation required the establishment of a physician fee schedule, based on a Resource Based Relative Value System (RBRVS), and a system of spending growth targets, known as the Medicare Volume Performance System (MVPS), and became effective January 1, 1992. As the RBRVS system was being developed, the procedural specialties were much more engaged than representatives of the cognitive services. As a result, the initial valuations greatly favored procedures. Unfortunately, pulmonary medicine, and particularly pulmonary procedures, did not fare well in the competition among societies to have the value of their services recognized. Despite the measures established by OBRA 1989, growth in federal expenditures exceeded federal targets. In response, the Congress took action in 1997 to replace it with the Sustainable Growth Rate (SGR), a formula to tie physician reimbursement to overall healthcare cost.

In 2001 the Department of Health and Human Services changed the name of the agency administering the Medicare program from the Health Care Financing Administration to the Centers for Medicare and Medicaid Services signaling the beginning of a significant policy and culture change. This marked the conversion from a check writing agency to one focused on transforming the healthcare system. Beginning with the Medicare Modernization Act of 2003 there has been a steady restructuring of the laws governing the Medicare program through the activities of the CMS Office of Legislation and friendly committees on Capitol Hill. Subsequent legislation authorized CMS to establish quality metrics and quality benchmarks, collect and compare provider performance, establish financial incentives based on provider performance and publish evaluations of provider performance in a public forum. Recognizing the failure of the Sustainable Growth Rate formula to meet its spending targets, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This legislation, which repealed the SGR formula, was hailed as the most significant Medicare reform in two decades. The legislation established programs that increased Medicare control over physician compensation and established financial levers designed to push physicians into contractual arrangements with entities in a position to exert administrative oversight of medical decisions. Recently, the CMS Administrator has communicated a vision of CMS as a public health agency seeking to use its influence, reimbursement systems, regulatory authority and leadership to seek widespread transformation of the entire United States healthcare framework. These efforts will use financial incentives and public reporting of physician cooperation to move the current practice of medicine to one that is federally monitored in near real time.

The Office of Inspector General and MedPAC

Two organizations that influence Congressional actions leading to the rules and regulations developed by CMS are the Health and Human Services Office of Inspector General (HHS OIG) and the Medicare Payment Advisory Commission (MedPAC). Reports to Congress from these organizations carry enough weight that CMS often acts before legislation is necessary to force the issue. MedPAC has just released its March Annual Report to Congress on the adequacy of provider compensation. In 2020 it is expected that the HHS OIG will release three reports important to our membership.

In 2018 the HHS OIG initiated studies on outpatient cardiac and pulmonary rehabilitation services, physicians billing for critical care evaluation and management services and payment for noninvasive home ventilators and respiratory assist devices. Previous OIG work identified outpatient cardiac and pulmonary rehabilitation service claims that did not comply with Federal requirements. The agency has been concerned that there has been inappropriate billing under 99291 and 99292 both in terms of the site of care and the time requirements. The agency has also been concerned about the increase in claims for home ventilators in recent years. In previous reports, the OIG found that in 2009 Medicare paid 2,528 claims for a home ventilator (E0464) at a cost of \$3.8 million and in 2015 the Agency paid 215,379 claims at a cost of \$340 million. While the cause for this dramatic increase in prescriptions was not investigated, the OIG indicated that fraud was suspected. Despite the efforts of NAMDRC leadership, federal agencies such as the HHS OIG and CMS continue to focus on the number of devices prescribed rather than the patient's medical requirements. The dramatic increase in home respiratory support parallels the improved science related to care of patients with different modes of respiratory failure. Unfortunately, despite the efforts of several societies, CMS still plans to include non-invasive home mechanical ventilation in competitive bidding, effective 1/1/2021.

On March 13 the Medicare Payment Advisory Commission (MedPAC) released its 2020 annual *Report to the Congress: Medicare Payment Policy*. In March of 2018 they released a strongly worded report critical of the Merit-based Incentive Payment System, established when the SGR payment formula was revoked, and recommended that it be repealed and replaced. This was reiterated in last year's report. In the Final 2020 Physician Fee Schedule Rule, CMS indicated that it was responding to MedPAC pressure and was embarking on yet another major revision of physician compensation. Designated as MIPS Value Pathways (MVPs), this program is anticipated to be implemented on January 1, 2021. The core of the new program will be increased sophistication of CMS electronic data collection and increased connectivity between physicians' electronic medical records and the CMS data base. There is an expectation that the physician electronic medical record will incorporate the data that CMS needs to develop the physician's "value score". CMS is scheduled to release the 2021 Proposed Physicians Fee Schedule in July. Proposed adjustments to the components of the MIPS and particularly the cost category will have a significant impact on our membership in 2021.

A Last Note

Under the forty year leadership of Phil Porte, NAMDRC has established a recognized advocacy profile with policy makers in Washington both in Congress and with federal agencies. Since its inception, the core principle of the National Association for Medical Direction of Respiratory Care has been improving the quality of patient care by reducing barriers to that care. The organization's priorities have been to identify issues unique to pulmonary medicine that lend themselves to legislative and regulatory action. In recent years the focus has been on improving access to home mechanical ventilation, appropriate use of supplemental oxygen and expanding pulmonary



**NAMDRC LEADERSHIP
2019-2020**

OFFICERS

James P. Lamberti, MD
President

Maida V. Soghikian, MD
President-Elect

Kathleen F. Sarmiento, MD
Secretary/Treasurer

Charles W. Atwood, MD
Past President

Board of Directors

Robert J. Albin, MD
Albee Budnitz, MD
Gerard J. Criner, MD
Laura Crotty Alexander, MD
Thomas Fuhrman, MD
Nicholas S. Hill, MD
Theodore S. Ingrassia, III, MD
Michael Nelson, MD
Steve G. Peters, MD
Chandan Saw, DO
Lisa F. Wolfe, MD

PRESIDENT'S COUNCIL

George G. Burton, MD
John Lore, MD
Louis W. Burgher, MD, Ph.D.
Alan L. Plummer, MD

E. Neil Schachter, MD
Frederick A. Oldenburg, Jr., MD
Paul A. Selecky, MD
Neil R. MacIntyre, MD
Steven M. Zimmet, MD
Peter C. Gay, MD
Steve G. Peters, MD
Lynn T. Tanoue, MD
Dennis E. Doherty, MD
Timothy A. Morris, MD

Executive Director

Phillip Porte

Associate Executive Director

Karen Lui, RN, MS

Director Member Services

Vickie A. Parshall

rehabilitation programs.

In the last two decades there have been significant advances in medical device technology and evidence based research has refined clinical practice. However, existing federal regulations have created barriers to advanced patient care in the field of pulmonary medicine. In the current regulatory environment, robust scientific evidence has not been sufficient to guarantee that a novel medical technique or device will disseminate into widespread use. With the shift to “Value Based Care”, the Centers for Medicare and Medicaid and their appendages such as the Durable Medical Equipment Carrier Medical Directors have circled the wagons and become much less responsive to input from our societies and patient advocacy groups. This has shifted the balance of determinants of innovation in medical care from factors such as clinical evidence and decisions made principally by physicians and scientists, to administrative decisions based on cost-efficiency and sociopolitical considerations.

In meetings with CMS staff, NAMDRC leadership has been left with the impression that current policy makers have difficulty understanding both the evolving sophistication in clinical medicine and the pulmonary physiology involved in newer support techniques. It appears that the major driver of change going forward will be through legislative activity. To advance any medical legislation will be a challenge as it will require a significant grassroots effort from concerned physicians, as well as patient groups. Individual physician contact with their legislators in Congress will be key to any advocacy effort. As Dr. E. Neil Schachter stated in his introduction to the third edition of *The NAMDRC Medical Directors Handbook* “The best defense against inappropriate governmental misdirection is the involved interest of informed physicians working together through an unfettered representative association.”

I would like to express my appreciation to both past and current NAMDRC Board members who have given me the privilege of writing the ***Washington Watchline*** for the last fifteen years.

Jim Mathers, MD, FCCP

PRODUCT AND TECHNOLOGY NEWS!

NAMDRC is providing this space to our benefactors and patrons who provide us with information about new products and innovations related to pulmonary medicine. NAMDRC reserves the right to edit this copy as appropriate.

NAMDRC Membership Benefits AT A GLANCE...

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

<https://www.namdrc.org/content/issue-advocacy>

One of NAMDRC's primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation's health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC's key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.