NAMDRC

WASHINGTON WATCHLINE

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

February 2020 *www.namdrc.org* *VOLUME 30 No. 02*

A Major 2020 Healthcare Legislative Deadline

In recent issues of the Watchline we have noted the increasing importance of federal legislation to achieve NAMDRC's goals of continuous improvement in patient care. The 2020 presidential election and current turmoil in Washington will make this a challenging, but hopefully not a lost year. The Congressional calendar will be limited in 2020 as incumbents, and some presidential contenders in the Senate, shift their attention to running for election. As is typical in an election year, the House and the Senate calendars are abbreviated allowing more time for members to campaign in their districts and the odds of a bipartisan compromise on any legislation are low. There are currently 1156 bills pending in the House and 413 bills in the Senate most of which will not pass out of committee and will expire at the end of the 116th Congressional session, January 3, 2021. There are, however, several prominent fiscal policy deadlines in 2020 that will force congressional action. One of these is a May 22 deadline to fund a number of important health care programs.

In the Fall of 2019, members of both the House and the Senate struggled to complete a spending bill to fund the government for 2020 and avoid a repeat of the very unpopular and expensive 2018 government shutdown. As the December 21 deadline for government funding drew near, legislators were able to agree on an appropriations package, however, they were unable to agree on the policies that would pay for a long-term funding of expiring health care programs. In an effort to offset some of the healthcare cost of the temporary extension Congress passed the *Creating and Restoring Equal Access to Equivalent Samples Act of 2019*. The goal of this legislation is to facilitate the timely entry of lower cost generic and biosimilar versions of high priced drugs and biological products. This change is projected to save the federal government $3.3 billion over 10 years by replacing brand names with generics in all federal programs. However, Congress will need to find more pay-fors by May when short-term extension of funding runs out. Members of the Senate Finance Committee, the Senate HELP Committee and the House Energy and Commerce Committee will be engaged in developing legislation that will pay for an extension of the existing health programs. In addition to finding savings to pay for the expiring

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

NAMDRC'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

NAMDRC 43rd Annual Meeting and Educational Conference will be held:
March 12– 14, 2020
The Scottsdale Resort at McCormick Ranch
Scottsdale, AZ

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

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

programs, these committees are under pressure from the administration to reduce total spending on Medicare.

Many of the health programs that will expire or run out of money in May 2020 include a number of community support programs which are important to key legislators. Among these are Medicare and Medicaid demonstration projects as well as outreach and assistance programs such as Community Mental Health Services, the Temporary Assistance for Needy Families program and the Child Care Entitlement to States. Also set to expire on May 22 is funding for the Community Health Centers Fund, the National Health Service Corps Fund and the Teaching Health Center Graduate Medical Education program. The May 22 deadline sets up the stage for a "must-pass" healthcare legislative package that presents an opportunity for several bills of interest to NAMDRC.

Recent legislative proposals have been targeting the cost of medications and the cost of hospital care. The administration is expected to lay out a pathway to implement a provision in a 2003 law that allows the importation of medicines sold abroad, if the Food and Drug Administration certifies the medicine as safe. The issue of allowing the government to negotiate drug prices for Medicare and Medicaid remains an option although opposed by the Senate Majority Leader. Finding ways to reduce the cost of hospital care has presented a challenge. Policy makers will continue finding ways to encourage more doctors to provide care through Accountable Care Organizations, medical homes and bundled payments. Further efforts to reduce hospital payments are being explored under the cover of eliminating "surprise billing." Legislation, introduced in the 116th Congress, has been estimated to save around $20 billion, but House and Senate lawmakers have been unable to come to an agreement on specific details.

A recent projection from the Congressional Budget Office suggesting that extending site neutral payments to currently exempted facilities has the potential to save $13.9 billion over ten years has caught the attention of the Administrators and Congress. This could put existing hospital based outpatient rehabilitation programs in further jeopardy. When CMS first started using site-neutral payments for outpatient services, policymakers carved out exceptions for some facilities. The majority of existing provider-based off-campus facilities and those that were mid-build were 'grandfathered' and able to continue billing Medicare at the much higher rate than independent offices for similar services. The Administration's 2020 budget proposed reform of the site-neutral payment legislation.

In the 2019 Outpatient Prospective Payment Rule CMS attempted to control the volume of Medicare billings arising from exempted hospital outpatient departments by extending the site-neutral payment policy to clinic visits performed at grandfathered off-campus hospital outpatient departments. The American Hospital Association, Association of American Medical Colleges, and three healthcare organizations sued HHS over this extension of the site neutral payments, arguing CMS did not have the authority to apply the payment methodology to grandfathered hospital outpatient departments. In September, 2019 a federal judge ruled that CMS had exceeded its authority. Despite this finding, CMS repeated its effort in the 2020 Outpatient Prospective Payment Rule. On January 13, The Association of American Medical Colleges, American Hospital Association (AHA), and several hospitals filed a complaint in the U.S. District Court for the District of Columbia that again challenges the reductions to certain grandfathered off-campus hospital provider-based departments. The complaint asks the court to declare the CY 2020 final rule as exceeding CMS' authority and to issue a preliminary and permanent injunction barring CMS from enforcing the payment reductions and ordering CMS to immediately pay the amounts that had been wrongly withheld from hospitals. While the CMS effort may again be defeated in court, it appears that many policy makers, faced with the need to reduce healthcare spending, regard this as low hanging fruit. Legislators and the Administration are not alone in this effort which has been supported by the Alliance for Site Neutral Payment Reform. National industry groups in the Alliance

include the American Academy of Family Physicians, America's Health Insurance Plans, Blue Cross and Blue Shield Association, American College of Physicians, and Large Urology Group Practice Association.

In 2008, NAMDRC worked closely with other interested parties to ensure passage of Section of 144 of the Medicare Improvements For Patients And Providers Act to establish pulmonary rehabilitation as a specific benefit category within the Medicare statute. Since Medicare adopted the site neutral payment policy, established by the Bipartisan Budget Act of 2015, NAMDRC has consistently pointed out how this policy discourages the expansion into the community of successful, hospital based, pulmonary rehabilitation programs. Healthcare proposals with the potential to reduce the frequency of hospitalizations for patients with pulmonary disease should be of interest to legislators. Evidence of the benefit of Pulmonary Rehabilitation programs continues to accumulate in the literature. An article from the National Heart and Lung Institute, Imperial College of London published in the October 2016 issue of CHEST drew our attention to the possibility of reducing hospital admissions for exacerbations of COPD. A summary of important efforts to reduce readmission of patients hospitalized with exacerbations of Chronic Obstructive Pulmonary Disease by Neil Freedman, MD, FCCP was recently published in CHEST 2019; 156(4):802-807. On review of current studies Dr. Freedman noted:

Pulmonary rehabilitation is now recommended for all symptomatic patients with COPD according to the most recent Global Initiative for Chronic Obstructive Lung Disease guidelines. Regular physical activity has been associated with reduced readmissions, and some, although not all, data support the impact of pulmonary rehabilitation within the first 4 weeks following discharge to reduce readmissions.

He also observed:

I think that most pulmonologists would agree that prescribing pulmonary rehabilitation immediately following discharge should be standard practice. Unfortunately, many barriers exist to implementing this intervention, including limited access to pulmonary rehabilitation programs at many hospitals, limitations by Medicare related to the number of phase II pulmonary rehabilitation trials a patient can attend, the cost of phase III pulmonary rehabilitation, and the need for transportation for patients who may be in a debilitated state.

NAMDRC has made efforts to have pulmonary rehabilitation programs carved out of the site neutral payment policy. HR 4838, introduced by Congressman Jim McGovern (D-MA), would exempt services from these restrictions when the total payment nationwide for a particular service by the physician specialty billing

the greatest amount under the physician fee schedule was under $2 million. For pulmonary rehab, the physician specialty billing G0424 the greatest aggregate amount is pulmonary, and that amount is actually under $500,000. In a more sweeping proposal, Representatives Derek Kilmer (D-WA) and Elise Stefanik (R-NY) introduced HR 2552, *The Protecting Local Access to Care for Everyone (PLACE) Act* on May 9 in an effort to block CMS from expanding the policy to grandfathered programs. Despite these bills, the increasing pressure to reduce Medicare spending and the campaign by the Alliance for Site Neutral Payment Reform will put a target on the backs of outpatient programs that were exempted in the original site neutral legislation with a May 22, 2020 deadline.

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.

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MEMBERSHIP OPPORTUNITIES WITH NAMDRC

INSTITUTIONAL MEMBERSHIPS

NAMDRC has restructured its membership opportunities to more accurately reflect how physicians practice medicine, acknowledging that genuine "private practice" is nowhere near as prevalent today as it was even five years ago. Physicians are now employees of hospitals and medical systems.

To improve our communication with you and hospital based colleagues, we have revamped our dues structure, with individual/small practice remaining basically the same as it is today. We are renaming our group practice options into two specific categories:

Institutional Membership/Gold for institutions that identify at least seven physicians, but no more than 20 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive two half price registrations for our Annual Conference at the standard member rate.

Institutional Membership/Platinum for institutions that identify at least 21, but no more than 50 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive four half price registrations for our Annual Conference at the standard member rate.

Small Group Practice (1-6 physicians)	$295 for renewal
	$395 for new member (includes one-time $100 initiation fee.)
Gold Institutional Membership (7-20 physicians)	$1750
Platinum Institutional Membership (21 – 50 physicians)	$2500

If you are based at a particular institution, we believe this is an excellent way to bring NAMDRC and its benefits to the attention of many of your colleagues. And the aggregate cost, per membership, drops dramatically under these new membership categories.

RENEW NOW!

JOIN NOW!

Go to www.namdrc.org and join and/or renew your membership online.

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8618 Westwood Center Drive, Suite 210
Vienna, Virginia 22182-2273

Phone: 703-752-4359
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NAMDRC INSTITUTIONAL MEMBERSHIP APPLICATION

Please select the category you are applying for:

☐ Small Group Practice (1-6 physicians)	$295/year for renewal
☐ NEW Small Group Practice (1-6 Physicians) *(includes one-time $100 initiation fee)*	$395 for new member/year
☐ Gold Institutional Membership (7-20 physicians) *Includes two half price registrations for NAMDRC Annual Conference at the standard member rate.*	$1750/year
☐ Platinum Institutional Membership (21-50 physicians) *Includes two half price registrations for NAMDRC* Annual Conference at the standard member rate.	$2500/year

INSTITUTIONAL MEMBERSHIP INFORMATION

Institutional Name: _____

Contact Person:_____

Email address: _____

Address: _____

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City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PAYMENT INFORMATION *(Make check payable to "NAMDRC")*

❒ American Express ❒ MasterCard ❒ Visa

Credit Card Number_____ Expiration Date _____CCV_____

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Printed Name_____ Signature _____

Email _____ Phone_____

USE THE ATTACHED MEMBERSHIP FORM TO LIST ALL MEMBERS OF YOUR GROUP

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NAMDRC
8618 Westwood Center Drive, Suite 210
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