



WASHINGTON WATCHLINE

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

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The 2020 Medicare Physicians Fee Schedule; Major Changes on the Horizon

The Centers for Medicare and Medicaid Services (CMS) issued the final rule for the 2020 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) on November 1st. With the budget neutrality adjustment to account for changes in Relative Value Units, as required by law, the finalized 2020 conversion factor is \$36.09, a negligible increase of \$0.05 above the 2019 conversion factor of \$36.04. Of course, actual physician compensation is subject to several factors including participation in Alternative Payment Models and scoring under the Merit-based Incentive Payment System program.

In July the Agency proposed and has now finalized significant changes to the way physicians will be compensated by the Medicare program in the near future. 2019 is the first year that physician compensation is affected by their performance in the Merit-based Incentive Payment System (MIPS). The initial requirements to avoid a reduction in compensation are minimal and do not include the Cost Performance Category. Very few physicians will notice a change in Medicare compensation this year. The 2020 PFS significantly accelerates the implementation of metrics that will make a noticeable impact on some physicians' Medicare revenue.

CMS has finalized an increase in the performance threshold, which is the minimum number of points necessary to avoid a negative payment adjustment, from 30 points in 2019 to 45 points in 2020 and 60 points in 2021. The inclusion of the Cost Performance Category in 2020 will have an impact on physicians with a large Medicare population in their practices. CMS had proposed to count the Cost Category as 20% of a physician's MIPS score for the 2020 performance year. However, in response to comments on the proposal, they have decided to keep it at 15%. By law, the cost and quality performance categories must be equally weighted at 30% beginning in the 2022 performance period. The impact of including the cost category was discussed in the January 2018 *Washington Watchline*.

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.

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**NAMDRC 43rd Annual Meeting and Educational Conference will be held:
March 12- 14, 2020
The Scottsdale Resort
at McCormick Ranch
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"NAMDRC will directly affect your practice more than any other organization to which you belong."

CMS has finalized the addition of ten episode-based measures to the existing eight measures that are used to calculate a physician's cost profile. Two measures related to pulmonary medicine will be part of the episode-based payment menu. An Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation measure will be added to the existing Simple Pneumonia with Hospitalization measure. The Agency has been in the process of developing specialty specific quality measure sets and has added the pulmonology measure set discussed in the August *Washington Watchline*.

On the bright side, CMS has finalized upgrades to compensation for outpatient evaluation and management services. The Agency has accepted the changes recommended by the American Medical Association Current Procedural Terminology (CPT) Editorial Panel for office visits. The new outpatient coding retains 5 levels of coding for established patients and reduces the number of levels to 4 for new patients. The CPT code changes also revise the time and medical decision making process for each of the codes and requires documentation of history and physical exam only as medically appropriate. The CPT code changes allow physicians to choose the visit level based on either medical decision making or time spent, including both face-to-face and non face-to-face time.

CMS has finalized a new Principal Care Management code that separately pays for care management of patients with a single, high risk chronic condition and a new code for additional time spent beyond the initial 20 minutes allowed in the current coding for chronic care management services. The reimbursement for transitional care management services, services provided to beneficiaries after discharge from an inpatient stay, has been increased. Details of these new and improved codes as well as the revised outpatient coding framework and associated Relative Value Units can be found in the September *Washington Watchline*.

The Revision of the MIPS Program; Introducing “MIPS Value Pathways”

As noted in the August *Washington Watchline*, CMS has come to realize that the MIPS program, as currently designed, will not have the desired impact on clinical practice. The program is not meeting the Administration's goal of accurately profiling individual physicians by cost and outcomes and there has been little movement of physicians out of MIPS/fee-for-service to Alternative Payment Models, despite the financial incentives designed to make participation in an Alternative Payment Model more attractive. At the urging of the Medicare Payment Advisory Commission, CMS is embarking on a major revision of the MIPS program, designated as MIPS Value Pathways (MVPs), to be implemented in 14 months 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's electronic medical record will incorporate the data that CMS needs to develop the physicians "value score". CMS is developing an electronic platform to gather patient input on the quality of care received from their physician. There will also be increased emphasis on claims-based quality measures that focus on both population health priorities and on a physician's cost profile.

The Future of the Quality Measures Component

One of the major flaws in the MIPS program has been the large number of useless quality measures on the menu from which each physician could choose. CMS found it impossible to compare physician practices when they chose different measures, even when treating similar clinical conditions. The agency has decided that a smaller and more focused set of quality measures, that can be accessed electronically, should be established. While the effort is introduced as the MIPS Value Pathways, as the discussion of the program progresses it becomes apparent that the designation MVP refers to discreet physician medical specialty and medical condition units comprised of sets of

clinical quality measures, with emphasis on cost and patient satisfaction, layered with population health measures. For example there would be an MVP for management of patients with diabetes or one for chronic obstructive pulmonary disease as well as an MVP for physicians primarily engaged in a specific domain such as pulmonology. Once the components for each MVP are established there would be no physician choice on quality metrics. A clinician or group would be in one MVP associated with their specialty or with a medical condition. The goal is to benchmark each physician against other physicians in the same specialty or caring for the same medical condition and arrive at a single “value score” that would be published on the Physician Compare website and in other media. CMS strongly believes that the value score is important to assist beneficiaries in the selection of a physician.

It may be of interest to some of our professional societies that CMS is exploring the concept of including a physician’s participation in specialty accreditation programs, developed by their medical society, as part of the practice improvement component of a physician’s value score. Since specialty accreditation programs may promote the improvement of clinical care, CMS believes it may be appropriate to incorporate attestation to participation in such programs.

Population Health Measures

The Agency has noted that commercial insurers use claims-based measures, such as preventable admissions and readmissions as population health measures. Currently, the MIPS program has one population health claims-based measure: The All-cause Readmission Measure. The Shared Savings Program has a measure, the All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions, that the Agency has decided to include in MIPS for the 2021 performance period. The Shared Savings Program also has a risk adjusted measure, the Ambulatory Sensitive Condition Acute Composite, which assesses the risk adjusted rate of hospitalization for a principal diagnosis of dehydration, bacterial pneumonia, or urinary tract infection. The Agency has requested assistance of clinician experts in identifying valid population health measures. In the proposed 2020 PFS, many commenters expressed concerns related to existing population health, claims-based, performance measures. Many commenters did not support the use of population health measures in MVPs because of concerns regarding reliability, validity, attribution and lack of risk adjustment as well as concerns regarding actionability and unintended consequences. CMS regards assessing the impact of an individual’s medical practice on population health as one of the pillars of the new program.

Patient Reported Measures

CMS will be basing a physician’s “value score” on the cost of care vs outcome of care modified by a patient satisfaction score. CMS intends to emphasize patient reported experience and satisfaction measures in this new program. MIPS currently includes patient reported measures such as optimal asthma control and measures for functional status assessment following hip and knee replacements. Currently, the Consumer Assessments of Healthcare Providers and Systems (CAHPS) for MIPS survey is available to group practices as an optional quality measure. However, there are no measures that are available or applicable to the majority of physicians in the MIPS program. CMS is making an effort to learn how patient reported information is being effectively used by commercial insurers to improve care and to assist patients with physician selection. The Agency is also studying how current commercial approaches for measuring the customer experience and satisfaction, outside of the health care sector, can be developed and incorporated into each MVP. The goal is to expand the information collected in the CAHPS and require integration of patient generated satisfaction data into a physician’s electronic medical record.



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Physician Practice Adjustments

As noted above, CMS expects physician practices to build out their electronic medical record infrastructures with components that align with the performance categories of the new program. The components include performance measurement tracking, performance improvement processes and data information systems that promote adoption of evidence-based, best practice, templates. It is expected that performance measure reporting for specific populations will encourage practices to build an infrastructure with capabilities to compile and analyze population health data. Since the goal of CMS is to use the MVPs program to move all practices into Alternate Payment Models, the Agency expects physicians to implement software that can constantly assess, reconfigure, and innovate processes and systems of care delivery to manage revenue and risk as they prepare to take on financial risk for patient outcomes.

CMS Issues an Invitation to Our Pulmonary Societies

In the 2020 Medicare Physicians Fee Schedule final rule, the Centers for Medicare and Medicaid has included many requests for help from medical societies. The Agency is well aware that they do not have the knowledge of the subtleties of clinical practice required to build out this ambitious program. It is clear from comparing the various publications released, in conjunction with the final rule, that the MIPS Value Pathways is more a concept than a defined program and that the divisions within CMS have varying views of the final product. For example, the press release accompanying the final rule states that this will be a program that will allow physicians to pick which clinically-related or specialty-specific MVP to report. On the other hand, the final rule language suggests that CMS intends to establish a methodology that allows the Agency to identify and assign the relevant MVP to physicians or physician groups in advance and require them to report on the assigned MVP so that they would be judged on the same measures and activities as other physicians treating a specific medical problem. Although there are many details to be worked out, the Agency is considering assigning an MVP to physicians and physician groups starting with the 2021 MIPS performance period.

As this new physician compensation program is developed, input from the leadership of our professional societies will be crucial to the future of independent practices. CMS has made it clear that they believe it is important to develop MVPs in unison with the leadership of professional societies to create low burden, meaningful MVP units and to ensure that MVPs are relevant to physician practices. They have requested help to determine the number of MVPs needed for specialists and which measures and activities should be included. Furthermore, they are interested in learning about specialty accreditation programs that demonstrate a commitment to quality improvement.

While this seems like an excellent opportunity to engage with CMS and to have an impact on the future of pulmonary medicine, an environmental scan may find that with the increasing percentage of pulmonary, critical care and sleep specialists who have moved out of private practice and are employed by large organizations, it may be a better use of time to encourage the remaining independent practices to find shelter in a reasonable Alternative Payment Model.

HAPPY THANKSGIVING!!!



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.namdr.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.

NAMDRC



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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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) \$395 for new member/year
(includes one-time \$100 initiation fee)
- Gold Institutional Membership** (7-20 physicians) \$1750/year
Includes two half price registrations for NAMDR Annual Conference at the standard member rate.
- Platinum Institutional Membership** (21-50 physicians) \$2500/year
Includes two half price registrations for NAMDR Annual Conference at the standard member rate.

INSTITUTIONAL MEMBERSHIP INFORMATION

Institutional Name: _____

Contact Person: _____

Email address: _____

Address: _____

City: _____ State: _____ Zip: _____

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

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

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