NAMDRC

WASHINGTON WATCHLINE

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

August 2019 *www.namdrc.org* *VOLUME 29 No.8*

The Proposed 2019 Medicare Physicians Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the 2020 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) on Monday July 29. In this proposed rule, CMS continues to emphasize the themes of accurately profiling the value of individual physician's services, adjusting payment policies to enhance payment for primary care and promoting telecommunication services. Notable in the 2020 proposal is the CMS response to the Medicare Advisory Payment Commission (MedPAC) criticisms of the Merit-based Incentive Payment System (MIPS), which we have previously noted in *The Washington Watchline.*

The 2020 Conversion Factor

In their March report to Congress, in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), MedPAC recommended no update to Medicare physician fee schedule rates for 2020. The MACRA legislation, which repealed the Systemic Growth Rate (SGR) formula for physician compensation, provided for an annual update of 0.5 percent to physician compensation through 2019. For the time period 2020 through 2024 it mandated no update to Part B services. With the budget neutrality adjustment, to account for changes in compensation for certain Part B services, the proposed 2020 PFS conversion factor is $36.09, a minimal change to the 2019 PFS conversion factor of $36.04. Of course, actual physician compensation is subject to several factors including participation in APMs and scoring under the Merit-based Incentive Payment System (MIPS).

The Merit-based Incentive Payment System Proposals for 2020

2019 is the first year that physician compensation is affected by their MIPS score. The initial requirements for avoiding a reduction in compensation are minimal and do not include the Cost Performance Category. Very few physicians will notice a change in

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."

Medicare compensation this year. The proposed 2020 PFS significantly accelerates the implementation of the program. CMS is proposing to increase the performance threshold, which is the minimum number of points to avoid a negative payment adjustment, from 30 points in 2019 to 45 points in 2020 and 60 points in 2021.

Furthermore, the inclusion of the Cost Performance Category will have an impact on physicians with a large Medicare population in their practices. With the 2020 PFS CMS is proposing that the cost performance category would make up 20 percent of a physician's final MIPS score for the 2022 payment year. The score for the 2022 payment will be based on data collected in 2020. The Agency plans to increase the weight of the cost performance category at increments of 5 percent each year until 2024. Therefore, the cost performance category would account for 25 percent for the 2023 payment year and 30 percent for the 2024 payment year. Any further increase in the impact of the cost category is limited by statute, however, legislative changes could occur as the MIPS framework evolves into the newly proposed MIPS Value Pathways program as discussed below. As CMS transitions the impact of the cost category from 20% to 30%, adjustments will be made to the quality category weight which will be reduced from 40% to 30% over the next three years. The practice improvement activities will remain at 15% and promoting interoperability will remain at 25%

In addition to the acceleration of the Cost Category impact, CMS is making adjustments to the components of the Cost Category. These adjustments include complex changes to the attribution methodology for the total per capita cost measure and the Medicare Spending Per Beneficiary (MSPB) measure and the addition of ten episode-based measures to the existing eight measures. *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*.

While CMS has set a minimum number patient encounters for each of the measures, most active pulmonary physicians will have a cost profile. For the total per capita cost measure, a global measure of all Part A and Part B costs incurred by a physician's Medicare population on an annual basis, CMS has set a case minimum of 20 beneficiaries. For the Medicare Spending Per Beneficiary clinician measure, an episode-based cost attributed to the physician that provides the plurality of services during a hospital admission, CMS has established a case minimum of 35 episodes. For the acute inpatient medical condition episode-based measures, a case minimum of 20 episodes has been established. CMS developed the episode-based cost measures in consultation with 10 clinical subcommittees, composed of more than 260 clinicians affiliated with 120 specialty societies, recruited through an open call for nominations between February 6, 2018 and March 20, 2018. The agency plans to continue on this path and has requested input, particularly from specialty societies, on potential additional episode-based metrics.

The Pulmonology Measure Set

In an effort to better measure the care provided by specialists, CMS has developed specialty focused measure sets, including a set for pulmonary medicine, proposed for addition to the 2022 MIPS Payment Year. The pulmonary measure set includes:

Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy: Percentage of patients aged 18 years and older with a diagnosis of COPD (FEV1/FVC < 70%) and who have an FEV1 less than 60% predicted and have symptoms who were prescribed a long-acting inhaled bronchodilator.

Advance Care Plan: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical

record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m2.

Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements and must contain the medications' name, dosage, frequency and route of administration.

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user.

Controlling High Blood Pressure: Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.

Use of High-Risk Medications in the Elderly: Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.

Sleep Apnea: Severity Assessment at Initial Diagnosis: Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis.

Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy: Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured.

Closing the Referral Loop: Receipt of Specialist Report: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

Optimal Asthma Control: Composite measure of the percentage of pediatric and adult patients whose asthma is well controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months and who received brief counseling if identified as an unhealthy alcohol user.

The Future of Medicare Fee for Service Compensation

When Congress repealed the SGR their goal was to replace it with a structure that accurately graded each individual physician on the "value" of their care. The four arms of the MIPS program were supposed to capture important data that could be combined to profile each physician, billing Medicare under fee for service, with a numerical value and compensate them accordingly. Physicians have been given the choice to either continue billing fee for service or joining and being compensated by an Advanced Alternate Payment Model (A-APM). Despite significant financial incentives to move to an A-APM, the great majority of clinicians participating in Medicare have elected to remain in fee-for-service. In the current performance period, CMS estimates that approximately 798,000 clinicians are participating the MIPS program for the 2021 payment year. The agency estimates that approximately 800,000 clinicians will be participating in the 2020 MIPS performance period while roughly 185,000 clinicians will be compensated by Advanced APMs.

MedPAC first signaled its concern with the structure of the MIPS program in its June 2017 report to Congress when it concluded:

MIPS as presently designed is unlikely to help beneficiaries choose clinicians, help clinicians change practice patterns to improve value, or help the Medicare program reward clinicians based on value.

In Their March 2018 report to Congress MedPAC stated:

There is growing consensus that the problems with MIPS are so fundamental that a different approach is required. MIPS will fail to improve patient care, even as it generates substantial administrative burdens.

MIPS is premised on the assumption that Medicare can measure and pay for high quality at the level of the individual clinician, and that assumption leads to a fundamentally unworkable program.

Putting a number on the problem, using CMS data, MedPAC pointed out:

Clinicians will spend well over half a billion dollars to comply with MIPS each year, without any clear impact on their quality of care. This is time and money that could be better devoted to patient care.

On May 8 of this year, the MedPAC Executive Director, James E. Mathews, Ph. D., Presented testimony to the Senate Finance Committee, again characterizing the policy as a failure and recommended replacing it with a "voluntary value program." It was suggested that such a program would consist of a uniform set of population-based measures for clinicians, who are not participating in an Advanced APM, using administrative claims to account for Medicare expenditures and emphasizing patient experience surveys to evaluate the quality of care.

Over the last several years the Commission has recommended that Congress add legislation that would provide bonus payments to physicians billing evaluation and management codes (E&M) and accepting responsibility for continuous patient care. Sadly, these recommendations have been ignored by legislators. In last year's report, to address several years of passive devaluation of ambulatory E&M services, they rec-

In the proposed 2020 rule, picking up on MedPAC's recommendations, CMS has signaled its intent to transform the MIPS program into one that more actively promotes movement of physicians out of MIPS/fee-for-service to Alternative Payment Models. The new program, which appears to be aligned with MedPAC proposals, is currently designated the MIPS Value Pathways (MVPs). CMS has proposed to implement the MVPs framework beginning with the 2021 MIPS Performance Year. In theory, MVPs will move away from the siloed and ambiguous, MIPS measures that have failed to meaningfully distinguish differences among clinicians. Two important aspects of the MVP program will be the development of a platform to gather significant patient input on the quality of care received from their physician and increased emphasis on a physicians cost profile. CMS has decided that physician evaluation should focus more on patient reported measures, including patient experience and satisfaction measures. Driving the acceleration in requirements is the CMS vision of a program that provides the information needed for patients to make their healthcare decisions.

Additional Issues in the 2020 Proposed Rule

This 1704 page document covers several additional issues pertinent to the practice of pulmonary and sleep medicine. These include revision of the outpatient CPT codes, a set of Medicare-developed HCPCS G codes for certain Chronic Care Management (CCM) services, new coding for Principal Care Management (PCM) services, expanding the concept of bundled payments, developing Patient Reported Measures and the development of new billing codes for Chronic Care Remote Physiologic Monitoring Services. We will be addressing these items in subsequent issues of *The Washington Watchline.* CMS has requested comments on all aspects of the proposed alterations to physician grading and compensation. There are opportunities for our societies to comment on and suggest measures for episode based payment, the Pulmonary Measures group as well as CMS's interest in telecommunication and telemedicine.

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.

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.

NAMDRC

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

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

Phone: 703-752-4359
Fax: 703-752-4360
Email: ExecOffice@namdrc.org Website: www.namdrc.org

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: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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

❒ American Express ❒ MasterCard ❒ Visa

Credit Card Number_____ Expiration Date _____CCV_____

Name as it Appears on Credit Card _____

Billing Address (If Different From Above) _____

Printed Name_____ Signature _____

Email _____ Phone_____

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

NAMDRC

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

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

Phone: 703-752-4359
Fax: 703-752-4360
Email: ExecOffice@namdrc.org Website: www.namdrc.org

NAMDRC INSTITUTIONAL MEMBERSHIP FORM

#	NAME	ORGANIZATION	MAILING ADDRESS	EMAIL
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

#	NAME	ORGANIZATION	MAILING ADDRESS	EMAIL
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

#	NAME	ORGANIZATION	MAILING ADDRESS	EMAIL
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				