NAMDRC

WASHINGTON WATCHLINE

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

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MedPAC Guidance to Congress on Medicare's Physician Compensation

In addition to promoting innovative treatments for patients with pulmonary disease, sleep disorders and the critically ill, one of NAMDRC's primary issues is fair physician compensation consistent with their training, expertise and contribution to patient care. As the major purchaser of healthcare, Medicare payment policy influences the payment policies of most commercial insurers. The influential Medicare Payment Advisory Commission (MedPAC) has established specific metrics to assess the adequacy of physician compensation and is required to submit reports to Congress in March and June of each year. Congressional policy makers depend on MedPAC to provide recommendations, supported by data, to inform evolving policy for physician compensation. Over the last decade, annual fee schedule updates have ranged from 0 percent to 1 percent, substantially less than the increase in the cost of providing care. Under current law, there will be no increase in Medicare's payment per Relative Value Unit (RVU) for 2020 through 2024. In its June 2019 report to Congress, MedPAC has taken a strong stance that, based on their methodology, the current level of physician reimbursement for services is appropriate.

The MedPAC Methodology

MedPAC analysts have designed a methodology, focused on measures of access to care, for evaluating the adequacy of physician compensation. As a direct determinate of access to care, the Commission sponsors an annual telephone survey of 4,000 Medicare beneficiaries ages 65 and over and 4,000 privately insured individuals ages 50 to 64. The total number of Medicare beneficiaries appears to be about 44 million. Indirect access measures include the number of physicians billing Medicare, the percent of physicians billing Medicare who are participants in the program, the percent of billing physicians who accept assignment and changes in the volume of services billed. The Commission also compares Medicare's payment rates to those in the private sector. The analysts have attempted to find reliable measures of the quality of care and the cost to practices to provide care but have not been successful. Using the above measures, the Commissioners have determined that payment updates over the last decade have been associated with generally stable access to clinician services for Medicare beneficiaries and that access for Medicare beneficiaries continues to be as good as or slightly better than access for individuals with private insurance.

*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."

The Telephone Survey

The results of the 2018 telephone survey were comparable with prior years' surveys. Roughly 3 percent of all Medicare survey respondents expressed a problem in obtaining a new primary care doctor in 2018, while 3.2 percent of all private insurance respondents expressed a problem. The percent of Medicare respondents facing a problem in obtaining a new specialist was 2.9 percent in 2018, and the share of private insurance respondents facing a small or big problem was 4.0 percent. In the survey, 70 percent of Medicare beneficiaries reported that they never had to wait longer than they wanted for routine care, and 79 percent reported the same for illness or injury care. Medicare beneficiaries were less likely to report trouble obtaining either type of care when needed than privately insured individuals.

In the report the Commission recognizes some of the problems with telephone surveys, however, the specifics of survey design were not discussed; the focus was on the increasing expense to the Commission. This is primarily due to a decline in the response rates resulting in a greater effort to obtain 8,000 completed responses by telephone. This has been attributed to the growing number of solicitations that households receive by telephone and the increasing use of voicemail and caller ID to screen calls. The effect of uneven geographic distribution and the possibility of bias in the respondents has not been discussed. The survey is felt to be valid because the analysts have been using the same method for a number of years.

The Profile of Clinicians Billing Medicare

In 2017, about 985,000 health professionals billed Medicare through the fee schedule, roughly 596,000 physicians and 389,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners. Over the past decade, the number of clinicians serving Medicare fee for service beneficiaries has increased as has the number of beneficiaries. The number of primary care physicians increased by 1.8 percent per year while the ratio of primary care physicians to the number of beneficiaries dropped slightly, from 3.6 per 1,000 beneficiaries to 3.5 per 1,000. The number of specialty physicians has increased by 1.5 percent per year the while number per 1,000 beneficiaries declined slightly from 7.8 to 7.7. Meanwhile, during the same period, the number of advanced practice registered nurses and physician assistants billing Medicare grew by 10 percent, and the number per 1,000 beneficiaries rose from 3.9 to 4.2.

The percent of physicians and other health professionals with signed Medicare participation agreements is very high, over 95 percent, and has been well above 90 percent for over a decade. Analysis of Medicare claims data shows that 99.5 percent of allowed charges for physician services were assigned; that is, for almost all allowed services, physicians agreed to accept the Medicare fee schedule amount as payment in full for the service. Changes in the volume of services delivered are believed to provide another indirect measures of access. From 2015 through 2017, volume growth rose modestly. Overall, volume per beneficiary, which reflects changes in both the units of service and intensity, grew about 1.0 percent per year between 2012 and 2016, with growth accelerating to 1.6 percent from 2016 to 2017.

Comparison to Commercial Insurance Rates

Based on the survey responses, the Commission reports that despite the higher private sector payment rates for clinician services of between 25 percent and 30 percent, access for Medicare beneficiaries remains as good as or better than access for privately insured individuals. Growth in the prices paid on an intensity adjusted basis 2012 to 2016 averaged 5.3 percent per year, whereas growth in Medicare's statutory update averaged less than a half a percent per year over the same time frame. To catch the attention of policy makers, the Commission has highlighted the belief that the higher level of payments by private sector payers for clinician services has not translated directly into improvements in patient access to care among privately insured individuals.

Inequality in Physician Compensation

In this report, the Commission reiterates its position that the Relative Value Unit system of compensation is a failure. For several years they have taken the position that cognitive services are underpriced in the fee schedule for physicians and other health professionals relative to procedural services. They point out that the

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current system allows certain specialties to increase the volume of services they provide, and the payments they receive, more easily than clinicians providing ongoing patient care. As they have pointed out on many occasions in the past several years, The American Medical Association Relative Value Update Committee has been slow to respond to the progressive devaluation of cognitive services:

Because estimates of time and intensity are not kept up to date, especially for services that experience efficiency improvements, the accuracy of the work RVUs has declined over time. Due to advances in technology, technique, and clinical practice, efficiency improvements are achieved more easily for procedures, imaging, and tests than for ambulatory E&M services, which are composed largely of activities that require the clinician's time and so do not lend themselves to efficiency gains. When efficiency gains reduce the amount of work needed for a service, the work RVUs for the affected service should decline accordingly. Because the fee schedule is budget neutral, a reduction in the RVUs of some services raises the RVUs for all other services. However, because of problems with the process of reviewing Mis-priced services, this two step sequence tends not to occur. As a result, ambulatory E&M services become passively devalued over time, while many other services become overvalued.

CMS, with input from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), has reviewed the work RVUs of many potentially mispriced services since 2009. However, CMS's review has taken several years and has not yet addressed services that account for a substantial share of fee schedule spending. CMS's review is hampered by the lack of current, accurate, and objective data on clinician work time and practice expenses. For example, CMS relies on data from surveys conducted by specialty societies to estimate clinician work time for specific services. These surveys have low response rates and low total number of responses, which raises questions about the representativeness of the results.

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 recommended a one-time 10% bonus to the fee schedule for ambulatory E&M services. Pulmonary office based practices would benefit from this bonus if it were implemented. That recommendation is reiterated in this year's report.

The MedPAC Position on the Merit-based Incentive Payment System

In their March 2018 report, the Commission strongly criticized the Merit-based Incentive Payment System (MIPS), and recommended that it be repealed and replaced (April 2018 Watchline). On May 8 of this year, the Executive Director, James E. Mathews, Ph. D., testified before the Senate Finance Committee again characterizing the policy as a failure and recommended replacing it with a clinician value-based purchasing program, a "voluntary value program." At this time, the recommendation reflects a conceptual direction as the Commission has not yet developed a plausible framework to fit their recommendation.

The Future of Medicare Compensation for Services

In 2017, Medicare paid $69.1 billion for clinician services delivered by over 1 million clinicians in all settings. It is the agency's goal to reduce this amount or at least hold it steady. MedPAC has endorsed the legislation that would not increase physician compensation in the next several years despite increasing costs of providing care. Recognizing the significant increase in the number of nurse practitioners and physician assistants and their billings under "incident to" physician services, which pays at 100% of the approved amount, the Commission has recommended eliminating "incident to" billing and requiring nurse practitioners and physician assistants to bill directly and be compensated at 85% of the approved amount. With the testimony before the Senate Finance Committee, MedPAC leadership is pursuing their goal of eliminating fee for service compensation. We will be alert to see if these positions have an effect on the proposed 2020 Physician Fee Schedule that will be released shortly.

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_____

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

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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

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