The 2015 brochure is now in production and will be mailed shortly! In the meantime, feel free to take a sneak peak of the 2015 NAMDRC Annual Meeting and Educational Conference.

[Link to brochure]

**CMS Methodology for Measuring Physician Costs**

Over the last three years, CMS has been developing the value-based payment modifier (VBPM) for the Medicare Physician Fee Schedule. The Affordable Care Act requires the VBPM to be phased in beginning in 2015 and be complete in 2017, when it would apply to all physicians. CMS is basing adjustments to physician compensation in any given year on a “performance year” two years earlier, which means that any payment adjustment for 2017 will be based on data collected in 2015. The value modifier will be applied to a physicians Medicare billings, possibly resulting in differential payment to physicians based on the quality of care they provide to Medicare beneficiaries compared to the cost of that care. Developing a methodology to profile an accurate cost of care for each physician submitting claims to Medicare has presented a significant challenge to the agency. The value modifier program is complex with many moving parts requiring sophisticated analysis of large amounts of data. A question raised by many observers is...
whether CMS can ensure the accuracy and stability of the methodology that will be used to score the cost and quality measures that will be applied to each physician's services. There are multiple metrics that will form the inputs to determine an individual's value modifier score:

Determining an individual's cost composite will be complex and of major importance to the compensation for services.

**Attribution of Costs**

The first step in determining a physician's cost profile will be attribution of a beneficiary to a physician or group of physicians. For the 2015 Value Modifier, CMS will attribute patients to physicians using the same methodology it used for the shared savings program. CMS has acknowledged that this method may not work well for certain large single-specialty groups and it remains untested for solo practitioners and small specialty practices. A Medicare fee-for-service beneficiary’s costs will be assigned to a provider when the beneficiary's utilization of primary care services meets a “plurality-minimum” standard. Primary care services will be identified by specific CPT codes, G codes, or revenue center codes and will include office-based, home health and nursing home codes. CMS defines primary care services as the set of services identified by CPT codes: 99201 through 99215, 99304 through 99340, 99341 through 99350, G0402, G0438 and G0439.
Medicare will assign beneficiaries to a physician or group practice at the beginning of a performance year by identifying all patients that had at least one primary care service with a provider, based on claims data, from the preceding year. Patient assignment will be updated quarterly based on the preceding 12 months of data. Final assignment will be determined after the end of each performance year, based on review of data from that year. In making the assignment, CMS will use a plurality-minimum method, in which a beneficiary’s entire cost of care for Part A and Part B services will be attributed to the provider who performed the plurality of the E&M services with a minimum percentage threshold of 20 percent of E&M services for individual physicians and a minimum percentage threshold of 30 percent of the E&M services for a physician group. CMS recognizes that Medicare fee-for-service patients may have seen multiple physicians with varying degrees of involvement. Under the current methodology a patient can be attributed to multiple physicians, each in a CMS defined care category. CMS has proposed that up to two physicians can “direct” care and up to five physicians can “influence” care, but multiple physicians can “contribute” to care.

**Determining Per Capita and Episode-based Cost**

The cost profile of each physician or group of providers will be assigned using the methodology developed for the Physician Resource Use Measurement & Reporting (RUR) Program. Anticipating legislation that would authorize CMS to reduce compensation for high cost/low value physicians, the agency embarked on the RUR program in January 2009. Based on the methodology developed under that program CMS has adopted five per capita cost measures for the 2015 Value Modifier. The cost measures are divided into two domains: one measure of total overall per capita costs for the assigned patient group, and one measure each of total per capita costs for assigned patients with one of four chronic diseases; chronic obstructive pulmonary disease (COPD), heart failure, coronary artery disease (CAD) and diabetes mellitus.

The 5 total per capita cost measures are annual measures that include the costs of all Part A and Part B spending during the year. These administrative, claims-based, cost measures will be used to develop a total cost composite score. Each measure within each domain is weighted equally and each domain is weighted equally to form a cost composite that will be compared to a national mean of costs. Recognizing that physiologic and social differences among beneficiaries can affect medical costs regardless of the care provided, CMS risk adjusts and standardizes payments for all cost measures. The risk adjustment methodology includes markers for patient demographics, socioeconomic factors, and prior medical diagnoses. Based on these characteristics, CMS risk adjusts the total annual per capita costs up or down for all of a physician’s Medicare patients. In the pilot resource use program, the average, non risk adjusted, total annual per capita costs for Medicare beneficiaries was $12,997. Costs ranged from $8,539 to $27,618, for a total annual per capita difference of $19,079. After risk-adjustment, the average adjusted annual total per capita costs was $11,983, with a range of $8,989 to $16,353, for an overall difference of $7,364. CMS will continue to collect data to establish national benchmarks for the five per capita cost measures.

**Hospital Readmissions Will Start to Affect Physician Compensation**

Since the physician’s cost profile will include all Part A and Part B claims submitted to Medicare on behalf of the patient, the cost of hospital readmissions will be incorporated as part of the total annual per capita cost measures assigned to each provider. This effect will be amplified in 2016 when the Medicare Spending per Beneficiary (MSPB) measure is added to the cost composite. The assignment methodology of this cost is not the same as that for the five cost measures discussed
above. This measure is an episode based cost measure and will be attributed to the provider that provides the plurality of Part B services during an index admission measured by standardized allowed charges. A provider must have a minimum of 20 MSPB episodes for inclusion of the MSPB measure in their cost composite. The MSPB measure will be the sum of all Medicare Part A and Part B payments during an episode spanning from 3 days prior to an index hospital admission through 30 days post-discharge. Since all Part A spending is included in the 30 day post-discharge window, Medicare Part A payments for a readmission that are included in an MSPB episode will increase the MSPB amount assigned to a physician or group practice. The MSPB measure will be added to the total per capita costs for all attributed beneficiaries and equally weighted with the total per capita cost measure. Therefore, readmission costs will have the effect of increasing total per capita cost profile for the provider to whom these patients’ costs are attributed. As a result, poor performance on controlling readmissions will have an adverse effect on a physician’s compensation for services.

How Will This Policy Apply to a Pulmonary Practice?

An example; if a pulmonologist evaluates a patient with COPD and submits a claim to Medicare for one of the initial visit CPT codes 99201 through 99205 with an appropriate ICD-9 code, that patient would be assigned to that physician under the directed, influenced or contributing categories. If the pulmonologist subsequently follows the patient and bills CPT codes 99211 through 99215 totaling more than 35% of that patient’s annual outpatient care, the pulmonologist would be considered the primary care provider and would be assigned the total annual Part A and Part B cost for that individual for the first domain as well as the Part A and Part B costs for a patient with COPD for the second domain. Yes it is additive, just as it will be for patients with heart failure, coronary artery disease and diabetes mellitus. If that patient is hospitalized and the same physician cares for the patient during the hospitalization, both Part A and Part B costs would be added to the physician’s profile under the MSPB policy. If the patient is hospitalized and another provider bills for the plurality of Part B services during that hospitalization, the costs would be assigned to the second provider under the MSPB policy.

How will Documentation and Coding Impact Your Cost Profile?

The VBPM outcome and cost measures have been developed using ICD-9 coded data to determine which patients will be included in a provider’s profile as well as to risk-adjust the analysis. We presume that CMS and physician practices will be able to make a smooth transition to ICD-10 or this already complex system could severely impact physician compensation in 2017. The implementation of ICD-10 will occur during the 2015 performance year so that the first three-quarters of the year will be based on ICD-9 codes while the remainder of the year will be based on ICD-10 codes. The number of diagnoses and the severity of illness reflected by the codes will determine attribution and risk adjustment used to measure physician cost performance, therefore, precise documentation is absolutely necessary to assign the correct codes and accurately demonstrate severity of illness.

The Path Forward

2015 is the first year that CMS will apply the value modifier starting with large medical groups and is the performance year for all physicians. CMS plans to continue the phased in approach to implementing the VBPM recognizing that there are important practical and methodological issues to be resolved. The process of cost attribution will start with acquisition of massive amounts of data. Based on 2012 claims data there are a total of 1,130,500 eligible providers submitting claims to Medicare, 815,294 of whom are physicians with 209,950 in solo practice, and 315,200 non physician
eligible providers. The Centers for Medicare & Medicaid Services (CMS) processes roughly 4.4 million claims daily. Medicare pays for more than 200 million office visits a year and was the primary payer for an estimated 15.3 million inpatient stays in 2011. The analytics that will be applied to that data have yet to be proven entirely accurate across the spectrum of physician activity. CMS staff have identified important statistical issues including accurate risk adjustment, patient attribution, performance benchmarks, defining peer groups, agreeing on minimum case sizes and compositing methods. They recognize that these parameters will continue to evolve and will require periodic evaluation.

Reflecting back on the implementation of the Resource Based Relative Value Scale (RBRVS), I believe society advocacy will be important to insure that all specialties are judged fairly. As the RBRVS was being rolled out some societies were more active in protecting their members interests than others. This resulted in significant inequalities in work values which were subsequently noted by MedPAC and are finally being addressed by CMS under their Potentially Misvalued Codes project. Adult critical care was not appropriately valued under the RBRVS and physicians engaged in delivering critical care services may be vulnerable to downward adjustments in their compensation under the MSPB component of the value modifier. Physicians will be receiving reports detailing their resource use prior to any financial adjustment. It will be difficult and time consuming for each individual to challenge these reports. NAMDRC staff may be able to help through their contacts with CMS administration. I would encourage you to notify the office if problems arise. Representation of a group will be more likely to have a favorable outcome than each individual trying to represent them self.
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.

http://www.namdrc.org/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 APPLICATION

**TWO EASY WAYS TO BECOME A NAMDRC MEMBER**

1. Go to [www.namdrc.org](http://www.namdrc.org) and register for membership online.
2. Mail this application to:

   NAMDRC  
   8618 Westwood Center Drive, Suite 210  
   Vienna, VA 22182-2222

Please print clearly or type:

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**FACILITIES WITH WHICH YOU ARE AFFILIATED**

Please indicate the areas that apply to your practice:

- Respiratory Care Management
- Hyperbaric Oxygen Therapy
- Anesthesiology
- Critical Care
- Sleep Disorders Pulmonary
- Home Health Services
- Pulmonary Rehabilitation
- Physiology Assessments
- Skilled Nursing Facility

**MEMBERSHIP DUES SCHEDULE**

(Dues for first year include $75.00 Initiation Fee)

**Individual and Small Group Dues..............$370.00**

Includes groups of up to 6. Please include contact information for all members.

**GROUP MEMBERSHIP DUES**

(For larger groups, please attach a list of names. If a group member wishes to receive mailings at an address other than that indicated above, please attach appropriate information.)

- Groups of 7-10.................................$1,175.00
- Groups of 11-20.................................$1,560.00
- Groups of 21-30.................................$1,930.00

**TOTAL PAYMENT DUE..........................$_______**

**PAYMENT**

- Enclosed is a check payable to NAMDRC (U.S. Dollars)
- Change my credit card for total payment due
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  - [ ] MASTER CARD

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**SIGNATURE**

In accordance with IRS Regulations, 95% of your 2015 Annual Dues are tax deductible. NAMDRC’s Federal TAX ID # is 74-2020988.

**FOR MORE INFORMATION, CONTACT NAMDRC**

Phone: 703-752-4359  
Fax: 703-752-4360  
E-mail: ExecOffice@namdrc.org  
Web Site: [www.namdrc.org](http://www.namdrc.org)

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**National Association for Medical Direction of Respiratory Care**

**Physician Advocacy for Excellence in the Delivery of Pulmonary, Critical Care, and Sleep Medicine**