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HPAC ESTABLISHES STRUCTURE FOR PRIORITIZED ISSUES

At its meeting on June 4, 2020, the Health Policy and Advocacy Committee (HPAC) confirmed the priorities identified in their initial meeting and established five work groups to focus on actions to meet established goals. The discussion included defining success for the five areas and noting which regulatory and legislative bodies would be involved. They also highlighted potential collaborative partners in each area such as sister societies and patient advocacy groups that might be involved in common causes. The existence of, or need for, data to support efforts was considered. This agenda is slated to be reviewed for adoption by the Board of Regents later this summer.

The groups are as follows:

- 1. Home Ventilation/Competitive Bidding.** Led by Peter Gay, MD, MS, FCCP, with committee members Nicholas Hill, MD, FCCP; David Schulman, MD, MPH, FCCP; and Lisa Wolfe, MD, FCCP.
- 2. Oxygen—Prescribing/Education.** Led by Robert DeMarco, MD, FCCP, with committee members Angel Coz Yataco, MD, FCCP, and Roozehra Khan, DO, FCCP.
- 3. Oxygen—Access.** Led by Neil Freedman, MD, FCCP, with committee members Angel Coz Yataco, MD, FCCP; Roozehra Khan, DO, FCCP; and James Lamberti, MD, FCCP.
- 4. Pulmonary Rehabilitation.** Led by James Lamberti, MD, FCCP, with committee members Michael Nelson, MD, FCCP, and Kathleen Sarmiento, MD.
- 5. Tobacco/Vaping.** Led by Laura Crotty Alexander, MD, with committee member Roozehra Khan, DO, FCCP.

Background and planned activities of the five groups will be featured in this and future issues of *Washington Watchline*. Involvement of CHEST members and allied supporters will be key to the combined success of the committee. HPAC encourages all CHEST members to familiarize themselves with the issues and attendant legislation that resonate most closely with the needs of their patients and individual practice settings to ensure a strong voice is ready to respond

HEALTH POLICY AND ADVOCACY COMMITTEE INITIAL MEMBERS AND STAFF

Neil Freedman, MD, FCCP
Chair

James Lamberti, MD, FCCP
Vice-Chair

Angel Coz Yataco, MD, FCCP

Laura Crotty Alexander, MD

Robert De Marco, MD, FCCP

Peter Gay, MD, MS, FCCP

Nicholas Hill, MD, FCCP

Roozehra Khan, DO, FCCP

Michael Nelson, MD, FCCP

Kathleen Sarmiento, MD

David Schulman, MD, MPH,
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Lisa Wolfe, MD, FCCP

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Michelle Kosobucki
*Volunteer Engagement
Specialist*

Jenny Nemkovich, CAE
*Chief of Staff and Senior Vice
President, Organization Affairs*

John Studdard, MD
Consultant

Be sure to check [chestnet.org](https://www.chestnet.org) and *CHEST Today* for COVID-19 related education, practice, and regulatory updates.

to regulatory and legislative considerations as they arise. HPAC members stand ready to share knowledge and expertise to enable an informed, coordinated, and active presence in this arena.

EFFORTS TO GAIN PULMONARY REHABILITATION COVERAGE EQUITY

“It takes more involvement of clinicians—people who are saying, ‘I can’t get what my patients need,’” asserts long-time advocate for pulmonary rehabilitation coverage, James Lamberti, MD, FCCP, who is heading the HPAC group responsible for advocacy efforts to change pulmonary rehabilitation health policy. Dr. Lamberti’s extensive career as a pulmonologist includes 21 years as Medical Director, Respiratory Care at Inova Fairfax Hospital in Falls Church, Virginia; President of NAMDRG; Medical Director of the Respiratory Care Program at Northern Virginia Community College; and Professor of Medicine at Virginia Commonwealth University School of Medicine, Inova Campus. Dr. Lamberti has seen the benefits patients gain from pulmonary rehabilitation programs—and the frustrations of the inadequacy of the current coverage. The combined voices of pulmonologists at hospitals across the country are needed to generate change in CMS reimbursement that will truly improve patients’ pulmonary health nationwide.

At a CHEST 2019 presentation, Dr. Lamberti identified three main failings of pulmonary rehabilitation health policy, highlighted from a 2016 study by Nishi and colleagues in the *Journal of Cardiopulmonary Rehabilitation and Prevention*: (1) lack of access; (2) inadequate reimbursement; and (3) inability to grow. Despite data from around the world confirming the benefits of pulmonary rehabilitation, only 3.7% of Medicare-eligible COPD patients receive it and only 43.5% of hospitals in the United States offer outpatient pulmonary rehabilitation.

Historically, CMS reimbursement has not been in line with hospital costs, nor have clinicians been proactive about providing justification to support efforts on behalf of hospital-based pulmonary rehabilitation programs. CMS created procedure codes in 2010 under the Outpatient Prospective Payment System (OPPS) and created an Ambulatory Payment Classification (APC) group that was based on insufficient data, which resulted in an inadequate initial median payment rate. Pulmonary rehabilitation is in need of attention as evidenced by the reimbursement rate in 2019 of \$55.90 per session compared with \$118.79 for cardiac rehabilitation.

The following was advised in a December 2018 policy briefing and recommendations [statement](#) addressing the burden of COPD in rural America to the National Advisory Committee on Rural Health and Human Services: “The Committee recommends that prior to

the next reevaluation of outpatient prospective payment rates, the Department of Health and Human Services consult with experts in pulmonary treatment to refine the definition of rehabilitation services and, in Medicare cost reports, confirm that there is adequate accurate data on this service to be used as a basis for the rate.” CHEST members who can share these data and point out the benefits of pulmonary rehabilitation programs are essential to moving this effort along.

While pulmonary rehabilitation is of great value to many recovering patients during the current COVID-19 pandemic, conducting programs and gathering data are challenging due to lack of quality reporting infrastructure as well as social distancing requirements. Telehealth coverage for pulmonary rehabilitation, another one of CHEST’s initiatives, can serve patients well under these circumstances.

Fixing the pulmonary rehabilitation inequities requires participation by clinicians who can and will champion access in their own institutions and submit charge data to CMS. Joining forces with like-minded physicians, through efforts CHEST will create to generate legislative and regulatory action, will result in better clinical situations for practitioners and ultimately for our patients.

TELEHEALTH COVERAGE EXPANSION EFFORTS

As reported in the June 2020 issue of *Washington Watchline*, CMS increased payments for audio-only telehealth visits retroactive to March 1, 2020. In continued efforts to make reimbursement permanent for some telemedicine visits, a [bill](#) was introduced by Representatives Glenn Thompson (R-PA) and G.K. Butterfield (D-NC). The proposed legislation (Helping Ensure Access to Local Telehealth [HEALTH Act]) would require federal regulations to be revised to deem telehealth services from an eligible provider as a “visit.”

CLINICIAN MATCHING NETWORK CONTINUES TO NEED HEALTH-CARE WORKERS

While the overwhelming need for qualified health-care providers on the front lines in New York has abated, the COVID-19 pandemic’s presence in other parts of the United States has increased, particularly in states that have re-opened public gathering places. The Navajo Nation, primarily in Arizona, is facing great need as this issue of *Washington Watchline* is being prepared. In its continuing effort to match health-care providers with systems in need during times of crisis, the American College of Chest Physicians (CHEST), the American Thoracic Society (ATS), and PA Consulting continue the Clinician Matching Network, a national-level clearinghouse

to pair providers with locations in need. To participate, indicate a southwest, or specifically Navajo Nation, placement. [Learn more and sign up today.](#)


CHEST'S CONTINUED COOPERATIVE EFFORTS: CORONAVIRUS PROVIDER PROTECTION ACT

Continuing its involvement in related professional societies' communication to elected leaders and regulatory agencies in response to unique situations resulting from the COVID-19 pandemic, CHEST signed on with 133 additional associations organized by the American Medical Association representing state, specialty, and national medical societies to advocate for passage of H.R. Bill 7059.

The [letter](#) points out the unique circumstances under which practitioners are providing care. In the letter addressed to bipartisan congressional leaders, they explain, "During this unprecedented national health emergency, physicians and other health care professionals have been putting themselves at risk every day while facing shortages of medical supplies and safety equipment, and making critical medical decisions based on changing directives and guidance. These physicians and other health care professionals are now facing the threat of years of costly litigation due to the extraordinary circumstances." They provide examples of clinical situations in which physicians are working outside their usual practice area, not having access to adequate testing and diagnostic aids, or having to delay treatment for other conditions during the pandemic. While beyond their control, physicians encounter the risk of medical liability lawsuits that may arise now or in the future.

The bill requests protection from unwarranted and unfair lawsuits specifically for health-care services that were provided or withheld due to circumstances related to COVID-19 when care was provided in facilities in good faith during the public health emergency.

CHEST urges members to communicate with their congressional representatives to lend their support to this bill.



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