LEGISLATIVE UPDATE

PHILLIP PORTE

EXECUTIVE DIRECTOR
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Phillip Porte was born and raised in Chicago, Illinois and completed his undergraduate degree at the University of Wisconsin with a Bachelors Degree in English and a minor in Political Science (1970).

After a relatively short stint with City New Bureau, CBS News, and St. Mary of Nazareth Hospital Center, all in Chicago, he arrived in Washington, DC in 1976 to work at the National Health Policy Forum, a foundation funded program that runs educational seminars for Federal health policymakers. While going to graduate school at the George Washington University in the Masters Program for Public Administration, he immersed himself in the nuances of national health policy. In 1978 he opened his own health care consulting and lobbying firm, representing the American Association for Respiratory Care. In the 31 years since, GRQ has established a strong reputation in the field of pulmonary medicine, representing NAMDRC as well as other pulmonary medicine societies, device manufacturers, pharmaceutical companies, and providers of hospital, nursing home and home care.

He has published articles in numerous journals relating to pulmonary medicine coverage and payment issues and has served as Executive Director of NAMDRC, a client of GRQ since 1979, for approximately 16 years.

OBJECTIVES:
Participants should be better able to:

- Understand the impact of Legislative & Regulatory activities on their practice of Pulmonary Medicine

SATURDAY, MARCH 14, 2015 9:30 AM
Legislative & Regulatory Update

38th Annual NAMDRC Meeting
March 12-14, 2015

DISCLOSURE

Mr. Porte serves as a consultant for Breathe Technologies, Covidien, Fisher Paykel and Philips, but these do not create a conflict related to the following presentation.
A Challenging Agenda

• Legislative Issues
  – Supervision of pulmonary rehab by NPPs

• Regulatory Issues
  – Home mechanical ventilation
  – CMS ignoring FDA classifications
  – Payment levels for pulmonary rehab/high Medicare Advantage co-pays

Legislative Issue

• Pulmonary Rehab
  – MD or DO must supervise the program under current CMS interpretation of law
  – PAs and NPs fill in for physicians throughout the Medicare program, except...
  – Physician supervision is uncompensated service, and the supervising MD not even required to ever step into the program, other than to be available in emergency
Pulmonary Rehab (con’td)

• S. 488, introduced by Crapo and Schumer, would resolve the issue. Doc fix would be vehicle
  – No cost because it is uncompensated service

Question # 1

CMS uses which two primary sources of data for determining payment for pulmonary rehab?

1. Cost for the service as submitted on claim
2. Charge of the service submitted on claim
3. Cost of overhead from annual cost report
4. Dartboard

A. 1&2
B. 1&3
C. 2&3
D. 1&4
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**Home Mechanical Ventilation**

**Background**

- Legis language Sec. 1834(a)(3)(A) states, “payment for a covered item, such as IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent devices with continuous airway pressure devices) for which there must be *frequent and substantial servicing in order to avoid risk to the patient’s health, shall be made on a monthly basis*...”
Question # 2

In addition to “frequent and substantial servicing,” the other primary payment methodology used by Medicare for ventilator payment is:

A. Cost as billed on claim
B. Capped rental
C. 80% of acquisition cost of device + DME overhead
D. Dartboard

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HMV (cont’d)

• CMS does not accept or recognize FDA classification of devices, notably ventilators.
• “Just because FDA calls it a ventilator, that doesn’t make it a ventilator”
• The only place where the term “respiratory assist device” appears is in CMS vernacular, ostensibly to get around the legislative language.

HMV cont’d)

• Add’l mindset, dating to 2001 CMS Decision Memo, signals that home vents are for trached or intubated patients and that ‘pulling the plug’ ostensibly leads to imminent death.
• NIV not part of the CMS thinking on “mechanical ventilation”
• CMS unable to cope with multi function devices
HMV (cont’d)

• CMS asks NAMDRC in March, 2014 to create a “white paper” on home mechanical ventilation.
• Team of national experts subdivide into 3 working groups: thoracic disorders, hypoventilation, COPD et al

HMV (cont’d)

• RADs not mentioned except in the context of CMS policies because this is clinical manuscript. For example, there are treatment algorithms to address the shifting needs of patients
HMV (cont’d)

• In Feb, 2015, a few months after submitting white paper *requested by CMS*, new policies, effective 10/1/15 announced:
  • Reiterates 2001 Decision Memo regarding home mechanical ventilation as unequivocally and only pertaining to life support/imminent death.

HMV (cont’d)

• In 2001 CMS stated
  “RADs provide noninvasive positive pressure respiratory assistance (NPPRA).... NPPRA is distinguished from the invasive ventilation administered via a securely intubated airway, in patient for whom interruption or failure of respiratory support leads to death.”
Question #3

• NAMDRC is considering several options for addressing this “disconnect.” Do you support:
  A. Working with CMS to negotiate reasonableness
  B. Fixing the legislative language to reflect current state of the art
  C. Using Congress (Repub) to lean on CMS (Dem)
  D. All of the above
HMV (con’td)

• Definition of central and complex sleep apnea to include CAHI index and expands signs & symptoms that describes these conditions
• Clarifies COPD that definitive testing is not necessary to exclude OSA when the clinical picture is sufficient
• For COPD, nocturnal oximetry is cumulative 5 minutes

HMV (con’td)

• Hypoventilation syndromes to remove FEV1
• PSG testing to also include HST when used in the inpatient hospital setting to establish or rule out diagnosis of OSA
• Ventilator section added to reflect 2001 ruling and April 2014 coding and coverage decisions
• Sleep test coverage and payment rules
CMS Ignores FDA Classifications

• Broad issue of vents in general
• Breathe Technologies NIOV device considered an oxygen accessory
  – Dr. MacIntyre, in meeting with NAMDRC and CMS administrator states, “ALL ventilators for patients who are hypoxemic (ICU to home) require compressed O2 to be effective.”

Medicare Advantage

• Federal law stipulates that the benefit package for Medicare Advantage MUST be at least as robust as fee-for-service Medicare.
• Some pulmonary rehab co-pays in Medicare Advantage plans are higher than FFS payment!
Pulmonary Rehab Payment

• Payment bump effective 1/1/2015, but hospitals need to adjust their charges to reflect the bundled service that became effective 1/1/2010. Even CMS acknowledges hospitals have not done so, resulting in lower payment than appropriate.

Question #4

The various Congressional/CMS programs targeting quality of care are:
A. Financially motivated
B. Quality motivated
C. Politically motivated
D. Likely to raise the floor of quality care
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