Legislative & Regulatory Update

NAMDRC Annual Conference

Sonoma, CA

March 27-29, 2014

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.

Legislative Issues

- SGR/Physician Fee fix
  - March 31, 2014 deadline
  - Key Congressional Cmtes agree on fix
  - “Pay for” not included
  - Shift at Senate Finance Committee
    - Baucus out
    - Wyden in

Patch vs Fix

- Politics indicates patch, probably until after 2014 election
- "Pay for" is the challenge -- $150B
- Genuine fix changes landscape of physician payment
- S2210 vs S 2000 vs S ???

Recent Wyden Bill (S2110)

- Repeal the SGR and end the annual political theater, while instituting a 0.5 percent payment update for five years.
- Improve the fee-for-service system by streamlining Medicare's existing web of quality programs into one value-based performance program. It increases payment accuracy and encourages physicians to adopt proven practices.

S 2110 (cont'd)

- Incentivize movement to alternative payment models to encourage doctors and providers to focus more on coordination and prevention to improve quality and reduce costs.
- Make Medicare more transparent by giving patients more access to information and supplying doctors with data they can use to improve care.
- Extend current law health care and human services policies that ensure affordable Medicare premiums for low- income seniors and guarantee beneficiaries have access to needed therapy services.

S 382

- Would permit NPPs to supervise pulmonary rehab
- Important distinction between CAHs and PPS hospitals
- CBO signals cost associated with CAHs
- Therefore, aggregate cost
- AACVPR will not support split to cover one and not the other

HR 2619

- Medicare Respiratory Therapist Access Act
- Intended to allow MD to receive $$ for RTs employed in "physician practice" for certain educational svcs tied to chronic care education/management
- Controversial with ACCP, ATS
- NAMDRC concerned about "physician practice"
- CBO score

Pulmonary Medicine Health Policy Summit

- April, 2013 – ACCP, ATS, AARC, COPD Foundation, NAMDRC
- Identify issues unique to pulmonary medicine that lend themselves to legis/regulatory action:
  - 02 reform
  - Telehealth/telemedicine
  - P4P, value based purchasing
  - Audits/documentation
  - COPD and public policy

NAMDRC Priorities

- Which Pulmonary Summit issue, in your view should be the highest priority for NAMDRC?
  1. 02 reform
  2. Telehealth/telemedicine
  3. P4P, value based purchasing
  4. Audits/documentation
  5. COPD and public policy

Which Pulmonary Summit issue, in your view should be the highest priority for NAMDRC?

1. 02 reform
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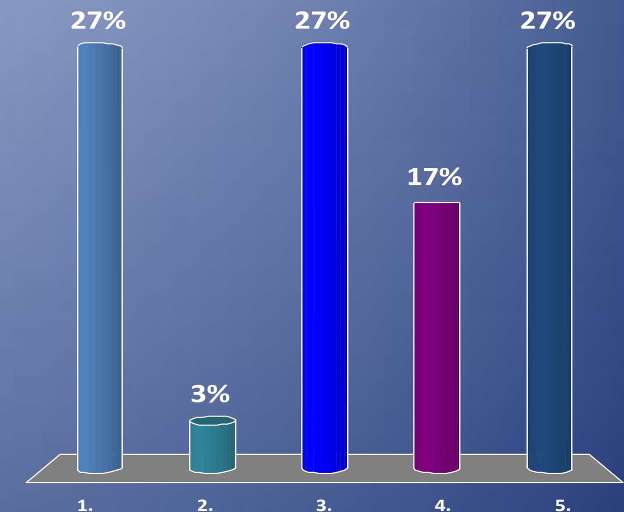
3. P4P, value based purchasing
4. Audits/documentation
5. COPD and public policy



COPD Readmissions

- The CMS COPD Readmissions Policy Affects
  1. Just COPD readmissions within 30 days, effective 1/1/2015
  2. All cause readmissions within 30 days, effective 1/1/2015
  3. Just COPD readmissions within 30 days, effective 10/1/2014
  4. All cause readmissions within 30 days, effective 10/1/2014

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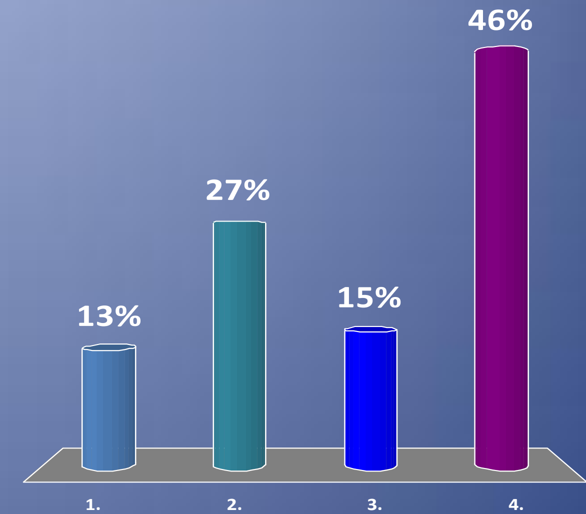

COPD Readmissions

- If implemented as planned, proposed rule this spring, final rule summer, implement 10/1/14
- **“All cause”**
- Mirrors CHF, MI, pneumonia policies
- Notable penalties – each hospital’s record
- No CPGs/standards of care
- CMS believes “Best Practices” is route to go
- NAMDRC conference March 7, including key societies (ACCP, ATS, AARC, AHA, ATA) + industry

Tools for MDs & Hospitals

- What tools do pulmonary physicians need to manage COPD discharges and "all cause" re-admmissions?
  - Payment for post discharge E/M (99495, 96)
  - Telehealth/telemedicine
  - Best practices?
  - Exposure for non compliant patient
- NAMDRC action

Non Face-to-Face Visits

- CPT codes for non face to face visits
  1. Are not recognized by Medicare
  2. Are recognized by Medicare for all contact 30 days post discharge
  3. Are recognized by Medicare for first bill submitted for each specialty
  4. Are recognized by Medicare for first bill submitted, only

E/M Services **NOT** Subject to the Guidelines (New 2013)

TRANSITIONAL CARE MGT SERVICES (TCM)

- **99495-99496 Discharged from hospital (acute, rehab, LTAC or SNF) to community setting (home, domiciliary, rest home or assisted living)**
- **Includes face-to-face and non-face to face time**

TRANSITIONAL CARE MGT SERVICES (TCM)

- The first face-to-face visit is part of TCM and may not be reported separately.
- Subsequent face-to-face visits may be reported separately.
- 99495 face-to-face visit must within 14 calendar days of discharge
- 99496 face-to-face visit must within 7 calendar days of discharge
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver must occur within 2 business days of discharge

TRANSITIONAL CARE MGT SERVICES (TCM)

- Non-face to face services provided by **clinical staff, under the direction of the physician or other qualified health care professional**, may include
  - Communication (with patient, family members; guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care and may include:

TRANSITIONAL CARE MGT SERVICES (TCM)

- Home health agencies and other community services
- Patient and/or caregiver education to support self-management, independent living and ADL
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family

TRANSITIONAL CARE MGT SERVICES (TCM)

- Non-face to face services provided by the **physician or other qualified health care provider** may include:
  - Obtaining and reviewing the discharge information (e.g. discharge summary as available or continuity of care documents)
  - Reviewing need for or follow-up on pending diagnostic tests and treatments
  - Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems
  - Education of patient, family, guardian and/or caregiver
  - Establishment or reestablishment of referrals and arranging for needed community resources
  - Assistance in scheduling any required follow-up with community providers and services

TRANSITIONAL CARE MGT SERVICES (TCM)

- Only one individual may report these services and only once per patient within 30 days of discharge.
- Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.
- The same individual may report hospital or observation discharge services and TCM
- The same individual should not report TCM services provided in the postoperative period

99495 **TRANSITIONAL CARE MGT SERVICES (TCM)**

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least *moderate complexity* during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 TRANSITIONAL CARE MGT SERVICES (TCM)

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making *high complexity* during the service period
- Face-to-face visit, within 7 calendar days of discharge

Competitive Bidding

- Based on my professional experience, the impact of competitive bidding on oxygen and sleep related products and services has been
  1. Minimal
  2. Notable, but manageable
  3. Tough for patients to navigate
  4. Very problematic for patients and physicians

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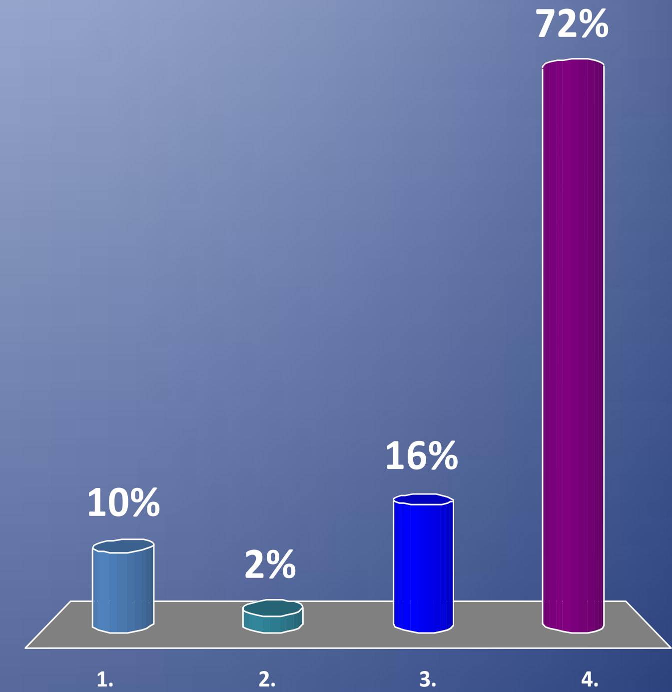

CMS Seeking Comment

- Notice at end of Feb deals with comp bidding & related matters
- Can comp bidding pricing info be used to establish pricing in non comp bidding areas
- Should next round of comp bidding involve bundled pricing
  - Cap rental goes away
  - Pendulum swings to other end of spectrum