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 17 years.

**OBJECTIVES:**
Participants should be better able to:

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

Mr. Porte serves as a consultant for Philips, but this does not create a conflict related to the following presentation.

Legislative & Regulatory Update

Sarah Walter
Phil Porte
NAMDRC Annual Meeting
Friday, March 24, 2017
Overview

• The Congressional Climate (not warming)
• NAMDRC Issues
  • Section 603
  • Home Mechanical Ventilation
  • APCs for Pulmonary Rehabilitation
  • MACRA

"It says our health insurance is being replaced by a series of tweets calling us losers."
ACA Repeal/Replace

- ACA subsidies replaced with tax credits indexed to income
- All ACA taxes (medical device, tanning bed, health plan, PhRMA, high income earners) repealed
- Individual mandate replaced by 30% surcharge on delayed enrollment
- Expanded HSAs
- Medicaid expansion ends after 2020
- Medicaid per capita caps
- No Medicare provisions
- CBO Analysis
  - 14 million more uninsured in 2018 (24 million by 2026)—many low-income 50-64 yr. olds
  - $337 billion in deficit reduction
  - Premiums 15-20% higher in 2018 and 2019

Timeline

- CR expires 3/31
- Senate vote on ACA and Judge Gorsuch prior to Easter recess
- Pivot to tax reform
- Debt limit reached late spring
- 9/30 Deadline to fund federal government for FY’18 and reauthorize CHIP
- December: Medicare extenders package and end-of-year funding
Audience Question #1

1. Congress will repeal and not replace
2. Congress will repeal and replace with something close to Ryan/Trump Care
3. Congress will repeal and replace with something close to Affordable Care Act
4. Congress will be stalemated on health care for the next 6 months.
New Management at HHS, CMS

- Tom Price is orthopedic surgeon
  - Hard grilling at confirmation hearings regarding ACA, stock purchases, etc.
  - Getting management team in place will take months
  - “Temporary” ban on communications with public

- Seema Verma at CMS has Medicaid, but virtually no Medicare experience.

Section 603 of BBA 2015

- Congressional Intent is to curb practice of hospital purchase of physician practices to increase Medicare reimbursement for virtually identical services

  - Makes sense for some services
  - Unintended consequences for others, such as pulmonary rehab

- CMS regulations effective 1/1/17 reimburse at physician fee schedule (about half of HOPPS for pulmonary rehab) rate for NEW or relocated services not within 250 yards of main campus.
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### Site Location

- The ONLY solution is legislative. Use documentation of physician services for Go424 to document that
- The service is generally NOT performed in physician offices;
- No measurable savings.
Site Location

- Options discussed with American Hospital Ass’n
  - Unique carve out;
  - Give Sec’y of HHS discretionary authority; or
  - When physician services billed through the Medicare physician fee schedule by all specialties do not exceed $500K per specialty, the provisions of Section 603 of BBA shall not apply to the specific CPT or HCPCS code when provided as a hospital outpatient service.

Audience Question #2

- In letter to NAMDRC regarding home mechanical ventilation:
  1. CMS stated “it’s complicated.”
  2. CMS stated “it’s a national and local issue
  3. CMS stated its “not a priority”
  4. All of the above
Audience Question #2
In a letter to NAMDRC regarding home mechanical ventilation:

1. CMS stated the “it’s complicated.”
2. CMS stated “it’s a national and local issue
3. CMS stated its “not a priority”
4. All of the above

Home Mechanical Ventilation

• Stonewall from CMS in fall of 2016
• Election changed our legislative strategy, process-wise
• Letter to Secretary Price
HMV – Legislative Recommendations (cont’d)

- Require HHS to to accept FDA product device classification of ventilators with respect to Medicare coverage and payment of such devices;
- Definition of “Respiratory Failure” and “Respiratory Insufficiency (political pluses and minuses) with five year sunset component;
- Preclude CMS from using health indicators for treatment of respiratory failure (including the imminent death standard) as a condition for coverage;

HMV – Legis Recommendations (cont’d)

- Through formal rulemaking in consultation with appropriate pulmonary medicine societies, define the following clinical categories for usage of ventilators and assign ventilators to each clinical category: nocturnal, intermittent, continuous use, as applicable
- Require that policies shall be based on peer reviewed scientific publications;
- Notwithstanding these changes, expenditures from home mechanical ventilation shall not exceed what would have been authorized prior to these amendments.
Respiratory Failure Defined

- Respiratory failure refers to sufficient impairment of respiratory function to cause severe mechanical and/or gas exchange abnormalities and eventually threatens the life of the patient. Respiratory failure can be acute, chronic, or acute on chronic. Respiratory failure requires a higher level of ventilator support than respiratory insufficiency. Patients requiring ventilator support most of the time are clearly in respiratory failure while patients requiring only nocturnal ventilator support may be considered in a state of respiratory insufficiency.

Respiratory Failure Defined

- Respiratory failure is defined as the inability of the respiratory system to maintain gas exchange within normal limits. The degree of respiratory failure may range from mild to severe with the severity determining the urgency and extent of treatment. It is generally divided into two forms:
  - Oxygenation failure – inability to maintain PaO₂ of 60 mm Hg or greater on room air and,
  - Ventilatory failure – inability maintain PaCO₂ of 50 mm Hg or below.
Respiratory Insufficiency Defined

• Respiratory insufficiency refers to impairment in respiratory function severe enough to interfere with activities of daily living or with maintenance of normal breathing function during sleep. Respiratory insufficiency is defined as “impairment in respiratory function severe enough to prohibit certain activities that the patient might normally pursue, and to interfere with daily living; occurring in association with abnormal measurements of respiratory mechanics and/or gas exchange.”

Audience Question #3

• Of the following, which are true:
  a. Hospitals bill over $120M annually for G0424 (pulmonary rehab)
  b. Medicare processes approximately 440,000 claims for pulm rehab annually
  c. Physicians billing through the physician fee schedule for G0424 about $5M annually

1. Only statement “a” is true
2. Only statements “a” and “b” are true
3. Only statement “c” is true
4. Statements “a” “b” and “c” are all true
Audience Question #3
Of the following, which are true:

a. Hospitals bill over $120M annually for Go424 (pulmonary rehab)
b. Medicare processes approximately 440,000 claims for pulm rehab annually
c. Physicians billing through the physician fee schedule for Go424 about $5M annually

1. Only statement “a” is true
2. Only statements “a” and “b” are true
3. Only statement “c” is true
4. Statements “a” “b” and “c” are all true

Pulmonary Rehab APCs

• Issue raised by CMS at Dec. 2106 meeting
• Is there value in combining pulmonary rehab and cardiac rehab into one APC?
• Replicating CMS payment methodology
  • Go424 (pulmonary rehab) would increase from approximately $56 to $98
  • 93797,98 (cardiac rehab) would decrease from $110 to $98.
• NAMDRC, ATS, CHEST/ACCP and AARC submit recommendation to combine to CMS in Feb, 2017.
**Merit Based Incentive Payment System**

- Statutorily mandated by MACRA
- Applies to physicians billing under fee-for-service

**Physician Cost Profile**

- Combines physicians’ Part B billing with portion of Part A costs as determined by CMS methodology. CMS acknowledges it may not work for certain groups, solo practitioners and small specialty practices.
- Continuous/broad
- Continuous/focused
- Episodic/broad
- Episodic/focused
- Only as order by another clinician
Episode Groups

- Chronic condition episode groups
- Acute inpatient medical condition episode groups
- Procedural episode groups

- Trigger codes: codes on claims that indicate a beneficiary has condition or treatment on CMS established list of episode based conditions.

CMS menu

- Includes 41 episode based conditions
- NONE are directly related to pulmonary services
- Pulmonologists billing at least 20 consultative services per year will be profiled.

- Under consideration: acute exacerbation of asthma/COPD, chronic care of COPD, inpatient care of CAP, outpatient care of CAP, acute pulmonary embolism, upper respiratory tract infection and acute deep venous thrombosis
Audience Question #4

1. I regret my vote in the 2016 Presidential election
2. I do not regret my vote in the 2016 Presidential election