

Medicare Respiratory Therapist Access Act - 2013

These Frequently Asked Questions (FAQs) are designed to provide insight into developing a legislative initiative, to discuss why AARC is taking a different approach in 2013, and to identify changes from last year's legislation. The document is for internal information purposes only. While the information provided is based on our best knowledge of the Medicare statute, regulations and other policies, it is important to note that only CMS can determine how the benefit will be implemented if Congress enacts the legislation.

Does AARC plan to pursue a legislative initiative in 2013 since we have been unsuccessful in the past in getting a bill enacted?

Yes. AARC is committed to getting the Medicare law changed to ensure that respiratory therapists (RTs) are given the recognition they so richly deserve. Currently, the law recognizes a number of allied health professionals such as physician assistants, nurse practitioners, clinical nurse specialists, social workers, and others. With changes in the delivery of pulmonary services over the past few decades, it is time for Medicare to acknowledge the value RTs bring to Medicare beneficiaries with chronic lung disease and the health outcomes that can be achieved with better access to RTs under Medicare Part B.

I've heard that AARC is revising the initiative we worked for over the past few years. Is this true?

Yes. As many of you know, we were unable to move our bill HR 491, the Medicare Respiratory Therapy Initiative, forward during the last Congress due to an unsupportable cost estimate from the Congressional Budget Office (CBO). After securing an independent analysis of Medicare data to show CBO that their cost estimate was overstated, preparing other background documents that supported a much lower cost estimate, and requesting a meeting with CBO staff to determine the assumptions they made in coming up with their estimate, we hit a dead end and were unable to convince CBO to change their assumptions or estimate.

With the federal deficit, spending cuts and sequestration at the forefront of Congressional debates, AARC recognized that to be successful in getting new legislation introduced in 2013 we needed to make changes that would yield a lower and more realistic score from CBO.

It seems that nothing ever gets done in Congress. Why is AARC still pursuing legislation when things seem so bleak?

AARC believes strongly that the Medicare program cannot continue with the status quo in the delivery of health care for patients suffering from chronic lung disease once they leave the hospital. Pulmonary patients do not get the tools they need to take care of their respiratory conditions and to self-manage their disease. As a result, costs skyrocket because the patients don't know what to do when an exacerbation occurs. Medicare beneficiaries are not taught to recognize the appropriate response to self-managing their chronic disease according to their symptoms. Consequently, most end up in the emergency department or being admitted or readmitted to the hospital which continues to add to the cost of care.

We want to change that. We want Congress to know that respiratory therapists make a big

difference in the lives of patients who suffer from chronic lung disease. Working with RTs, beneficiaries who are properly taught to self-manage their chronic lung disease can, with regular and consistent self-care, slow the progression of their disease and reduce hospital costs and readmissions by eliminating the need for acute care interventions when an exacerbation occurs. This is especially important since COPD will most likely be added to the conditions in 2015 under the Hospital Readmissions Reduction program.

What is AARC proposing for 2013?

AARC is proposing a new initiative called the **Medicare Respiratory Therapist (RT) Access Act**. It is designed to cover “pulmonary self-management education and training services” when furnished by qualified RTs in the physician practice setting for Medicare beneficiaries who have been diagnosed with COPD, asthma, pulmonary hypertension, pulmonary fibrosis and cystic fibrosis. **A copy of the proposed draft language is provided on the PACT secure site and the AARC website.**

What do you mean by “pulmonary self-management education and training”?

Only CMS can decide what constitutes coverage under this term. It most likely would involve providing general information about the patient’s particular disease, observing and teaching proper inhaler techniques, stressing the importance of adherence to medications, making recommendations about flu and pneumonia vaccines, and perhaps developing an action plan so patients understand how to manage their symptoms to prevent exacerbations, etc. Smoking cessation counseling is not considered “training and education” but would be covered under the patient’s plan of care as a separate benefit.

Aren’t self-management services covered now?

No. While CPT codes exist for “education and training for self-management when furnished by a non-physician health care professional”, Medicare does not pay for the services. Also, because RTs are considered auxiliary personnel in the physician office setting they cannot provide these services currently. Enactment of the **Medicare RT Access Act** would fix the problem; i.e., the services would be covered and RTs would be able to furnish them. That is why we need to have the law changed. If CMS follows the precedent for diabetes self-management training, they will most likely establish two new G codes that address “pulmonary” self-management education and training” specifically.

Why did AARC pick pulmonary self-management education and training over other RT services?

The AARC wants to position RTs to be at the forefront of initiatives that improve quality care and keep pulmonary patients healthier. Implementation of the Accountable Care Act is changing the paradigm by introducing new and innovative payment models that emphasize the importance of primary care physicians, care coordination, bundled payments, medical homes, and Accountable Care Organizations. Patient education and self-management before and after release from the hospital has been recommended by the Medicare Payment Advisory Commission, an independent group of experts who advise Congress on various Medicare payment strategies, as

a way to prevent hospital readmissions. Further, the Department of Health and Human Services, working with the National Council on Aging, has set a goal to make self-management an integral part of the health care system for individuals suffering from multiple chronic conditions by 2020. The **Medicare RT Access Act** would help achieve these goals

How different is the new proposal from the old?

A number of things are different in the new initiative. They are discussed in detail below.

Covered Services are Limited

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| New | Only “pulmonary self-management education and training services” will be covered. |
| Old | RT services typically furnished in an office setting as part of the RT’s scope of practice that otherwise would be services furnished by the physician would be covered |

Discussion: As you can see, the new 2013 initiative is limited when compared to last year’s initiative that would have permitted RTs to furnish any service appropriate for the physician practice setting as long it is within the RT’s scope of practice. We cannot emphasize enough the need to present a more balanced and reasonable approach to revising the Medicare law given the fact that the climate in Congress today is much different than it was when we first started our effort. We believe it is important to learn from our previous experience and make improvements that ensure victory.

Taking a small step is better than no step at all. The precedent for Medicare coverage of self-management education and training services was established some time ago for diabetes outpatient self-management and training services. So another plus for our new focus is that it is consistent with previous amendments to the Medicare law. Like the diabetes legislation, pulmonary self-management education and training would only be covered if the physician indicates in the patient’s plan of care that the service is reasonable and necessary.

Coverage of Patient’s Respiratory Condition is Limited

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| New | COPD (including emphysema and bronchitis), asthma, pulmonary hypertension, pulmonary fibrosis, and cystic fibrosis are covered diagnoses. |
| Old | The bill did not limit the respiratory diseases that would have been covered. |

Discussion: We have kept the covered diagnoses to a minimum because AARC believes it can improve our chances of securing a reasonable and appropriate cost estimate from CBO. For example, we removed coverage of “other chronic respiratory diseases as determined by the Secretary” from earlier draft language because other diagnoses would have to be considered in coming up with a cost estimate.

RT Qualifications Revised

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| New | The RT must hold a RRT credential and “at a minimum have a bachelor’s degree or other advanced degree in a health science field.” |
| Old | The RT must hold a RRT credential and a bachelor’s degree. |

Discussion: Allied health professionals who are currently covered under the Medicare law such as physician assistants, nurse practitioners, clinical nurse specialists, and others generally must

meet education, training and other requirements in a field related to the services they provide. In some cases, the professional must hold a master’s degree at a minimum to be considered qualified.

In reconsidering changes to our Medicare initiative, AARC believes it is more consistent with current Medicare law if the RT’s bachelor’s degree is related to a health science field appropriate for the practice of respiratory therapy. Since we have inserted the word “or” in the qualification language, a RT who has a bachelor’s degree in an unrelated field but a master’s in a health science field should still meet the qualification standard.

General Supervision Requirement Eliminated

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| New | The RT will work under the “direct” supervision of the physician as required by the “incident to” rules. |
| Old | The RT would work under the “general supervision” of the physician; that is, the physician does not have to be present in the office suite at the time the service is furnished. |

Discussion: We believe the “general supervision” requirement in our previous initiative added considerably to the cost of the bill because CBO saw this as a way for physicians to increase their utilization; that is, bill for a lot more services than what they would get paid without any legislative change. Under the **Medicare RT Access Act**, the physician will have to be present somewhere in the suite when the RT provides a service, i.e., direct supervision. “Direct supervision” should not be viewed as a downside since our new initiative permits coverage of services when furnished by qualified RTs that Medicare does not pay for currently, thus providing an incentive for the physician to hire RTs for his or her pulmonary patients who need the expertise RTs can provide.

Physician Payment Revised

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| New | The physician will be paid consistent with rules that apply to “incident to” services and the physician fee schedule. |
| Old | The physician would be paid less than the fee schedule amount. |

Discussion: Since physicians bill Medicare for the fee schedule amount under current “incident to” rules, it would be a disincentive to reduce the physician’s payment amount for services to be covered under the **Medicare RT Access Act**. The reduced payment to the physician in our old bill was tied to the “general supervision” provision. Because it offered an opportunity for the physician to bill for extra services, a way to keep costs down was to make the additional payment lower.

With all the changes that are being made, is there anything from the original initiative that didn’t change?

Yes, there are several things that remain the same.

- The legislation is still focused on the physician office/practice setting.
- It is still part of the “incident to” benefit category.
- RTs cannot bill Medicare directly; the physician will bill Medicare.
- RTs cannot start their own independent practice.

- RTs can be part-time or full-time employees of the physician or be contracted to provide the services.

What is the incentive for the physician to hire a qualified RT if only “pulmonary self-management education and training services are covered?”

Hiring a RT enables the physician to get paid for a service that Medicare does not cover. It is a win-win for the physician, RT and pulmonary patient because once a RT is hired and you have your foot in the door, there is nothing to preclude the physician from having you furnish other services that are within the RT scope of practice and are permissible under the “incident to” benefit.

The Medicare program is changing the way health care is delivered today based on programs mandated by the Accountable Care Act. With increased emphasis on linking payment incentives and penalties to the quality of care provided as compared to the cost of that care, it is important now more than ever that physicians do the best job they can to keep their patients as healthy as possible. COPD, asthma and smoking cessation are getting a lot more attention as new quality measures are being added to physician reporting requirements. Beginning in 2015, certain physician practices can receive incentive payments if they report a range of quality measures that indicate better care for their patients. Having the expertise of a RT can help them achieve their goals.

Isn't it important to have a “pay for” when a bill is introduced? What is AARC doing to address that issue?

In order to develop a “pay for”, we first have to know what the legislation will cost. Because the **Medicare RT Access Act** will add new covered services, it is inherent that there will be associated costs. We also expect that savings can be achieved by reducing the number of emergency room visits and/or hospital admissions/readmissions for those pulmonary patients who receive RT self-management education and training. That’s why we have commissioned an independent firm to develop a “CBO-like” cost estimate. This effort is designed to help with sponsorship on the Hill. However, regardless of what the independent analysis shows, we expect Congressional staff will still want a CBO score in order to move the legislation forward.

We recognize that not having a “pay for” in our previous bill put us at a disadvantage in getting our legislative initiative enacted even though there was significant support. Part of the problem stemmed from our inability to get the issue resolved with CBO. This is a long way of saying we’ll deal with a “pay for” for this year’s legislation once we know the anticipated costs.

I work in a physician practice now and don’t meet the criteria under the *Medicare RT Access Act*. Can I lose my job?

No. If you are a CRT or a RRT without a bachelor’s degree in a health science field, the services you have been providing as “incident to” will not change.

I'm a respiratory therapist who doesn't meet the qualification criteria. Why should I work and lobby for this initiative?

It is important for you to support this Initiative because Medicare recognition of RT services under Part B enhances both the profession and the respiratory therapist. It expands what the profession can do and it gives visibility to the RT that does not exist under the current law. This is especially important at a time when millions of new Medicare beneficiaries will be added to the rolls, when there is an ever-increasing emphasis on COPD and its high-rising cost of care, when the shortage of physicians continues to grow, and when quality care and performance not only for hospitals but individual and group practice physicians continues to be scrutinized. Just because you may not hold the credentials required to qualify under the **Medicare RT Access Act** does not mean you are left out. You can still work in the physician's office and furnish services that fall under the general rules that apply to the "incident to" benefit.

I'm a respiratory therapist who works in the hospital. This Initiative impacts respiratory therapists who work primarily in a physician office practice. Why should I care and work for this?

We see our initiative as opening up new employment opportunities and career advancement for the respiratory therapist. It not only enhances the profession but it also raises the stature of the RT in the eyes of all health care providers. And, that will benefit you. You may one day want to work outside the hospital and as a qualified RT a new door would be opened. Even if you always choose to be employed in the hospital, your colleagues might want to move on and be employed in a physician office practice with greater independence. If enacted, the **Medicare RT Access Act** will do just that.