Subacute Care Bulletin

Jan./Feb. '99

American Association for Respiratory Care

Notes from the Chair & Editor

by Becky Mabry, RRT

Respiratory therapists who focus their activities in the post acute sector – particularly subacute and long-term care – faced significant challenges in 1998. Last July, the first wave of skilled nursing facilities (SNF) began a three year transition into a prospective payment system (PPS) for Medicare patients. Acronyms like "MDS" and "RUGs" bombarded administrators as facilities struggled to understand PPS reimbursement and its implications, not only for patient care but also for the financial viability and survival of their facilities.

The fall-out for respiratory personnel has been significant due to the exclusion of respiratory therapy services as an ancillary rehabilitation service under PPS. Reimbursement for rehabilitation as an ancillary service is only provided for speech, occupational therapy, and physical therapy. Under PPS the SNF is responsible for all billing to Medicare and there is no cost pass-through for ancillary services. In the past respiratory care was often billed as a pass through ancillary service, and payment was more likely to reflect the actual cost of providing respiratory care services.

Respiratory care services reimbursed via PPS are included as part of the "special care" or "extensive care" categories in the Resource Utilization Groups, third edition (RUGs-III). Patients admitted to long-term care under PPS are clinically assessed using a federally-mandated Minimum Data Set (MDS). The MDS assessment and plan of care determine the resource intensity needs of the patient and correlate to a RUGs classification. The RUGs category drives the Medicare per diem reimbursement for the patient's care as outlined in the May 1998 *Federal Register* (see Table 1).

All SNF-based subacute units will be covered under the PPS program by June of this year. Subacute programs that were in existence in 1995 are classified as existing programs and have a three year phase in. In year one Medicare patient reimbursement is based 75% on the facility's current costs and 25% on the new PPS. In year two reimbursement is based 50% on current costs and 50% on the new PPS. In year three reimbursement is based 25% on current costs and 75% on the new PPS. By year four the facility receives reimbursement at the PPS per diem rate based on the patient's RUGs classification. There is no transition period for new facilities or facilities with subacute programs that are less than three years old. An established subacute care unit in a SNF that admitted higher acuity patients in 1995, with correspondingly higher ancillary costs, is likely to fare better initially under PPS because of the three year weighted phase in of PPS.

Table 1.

RUGS-III Categories	Per Diem Reimbursement Range*
Rehabilitation	$178 - $408
Extensive Services	$191 - $253
Special Care	$177 - $187
Clinically Complex	$147 - $189
Impaired Cognition	$124 - $142
Behavioral Care	$119 - $141
Reduced Physical Function	$117 - $153

*The per diem reimbursement range varies based on the specific RUGs classification and due to the distinction HCFAmakes between reimbursement for rural facilities versus urban facilities.

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All these changes have led to a tremendous amount of confusion and misunderstanding in the industry, resulting in the cancellation of transfer agreements between hospitals and SNFs and the termination of respiratory therapy service contracts. But the reality is that hospitals still have medically complex respiratory patients who will qualify for subacute respiratory care services. In 1996 4.2 million of the 13 million Medicare beneficiaries who were in a SNF or hospital received respiratory therapy services. In order to survive in this uncertain environment, therapists must have access to timely updates about PPS and how respiratory care fits into the overall program.

During the Subacute Care Specialty Section Business Meeting at the AARC Congress in Atlanta this past November, several initiatives were suggested as goals for the section in 1999. These include:

- Develop an MDS/RUGs-III task force to provide timely updates via the AARC web site on strategies for managing respiratory patient services and reimbursement under PPS. This task force will also develop informational articles for this *Bulletin* and other AARC publications on how to understand and utilize the MDS to ensure proper RUGs-III classification of patient acuity and resource needs.
- Disseminate information about how the fiscal intermediacies are interpreting PPS and its impact on RTs on a local and regional level.
- Propose a model for competency testing for nurses who provide respiratory care in the subacute setting. The model must take into account the specific issues related to post acute care and the interaction between nursing and the skilled RT.
- Cultivate a network of allied professionals who are educated in the benefits the RT provides in terms of reduced length of stay (LOS) and better, more cost effective care for respiratory and pulmonary patients cared for in the SNF.

Several individuals expressed their desire to participate in these task forces and in achieving the goals outlined above. It is my goal to publish a list of individuals who will be heading up these initiatives in the next issue of the *Bulletin* and to make this list available to section members via the AARC web site. In addition, we need section members who were not in attendance at the meeting to volunteer and contribute their time and expertise to these activities.

The section also needs guest editors for the *Bulletin* and a group of web-savvy individuals to act as Subacute Section web-watchers. There is a tremendous amount of expertise and energy in this specialty section. RTs in subacute care have helped to build an industry. The same drive and focus that built the industry can help to steer a safe passage through the troubled sea of change wrought by the recent changes in Medicare reimbursement. My contact information appears on page 2 for anyone who would like to help. Thank you in advance for your participation in, and support of, these endeavors. ■

Subacute Care Bulletin

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Letters to Congress: If We Don't Tell Them, Who Will?

by Cheryl A. West, MHA, AARC director of government affairs, Washington, DC

As all of you in subacute care are well aware, the implementation of the Medicare Prospective Payment System (PPS) for Skilled Nursing Facilities (SNFs) has resulted in negative repercussions in both the quality of patient care provided in nursing homes and the employment of respiratory therapists in these facilities.

Part of the AARC's overall strategy to combat the decrease in the quality of respiratory therapy services that are provided by nursing homes is to require nursing homes to meet minimum competency standards for those individuals providing respiratory therapy services in SNFs.

After meeting several times with HCFA, it is clear that the agency lacks the authority to quickly implement competency requirements for nursing homes. Therefore, it will be necessary for Congress to legislate such an authority. In order for members of Congress to support a legislative effort, it is necessary for them to hear from their constituents (you).

The AARC needs you to write letters to both of your Senators and your representative in the House of Representatives. Because form letters have little impact, we are instead providing you with the key points that should be included in your letter. Following this article is a synopsis of the issue, which you should attach to your letter.

Please be aware that while the issue of competency is currently focused on the nursing home environment and the SNF PPS, HCFA is developing prospective payment systems for other care settings as well. The challenges we face in the SNF arena may very well confront us again in other areas of care where respiratory therapists are employed. This prospect behooves all respiratory therapists to speak out now about the issue of competency. Please share this appeal with your colleagues, and encourage them to take action. There is strength in numbers, and the Association needs the support of as many practitioners as it can get.

Here are the key points to include in your letters:

1. In the first paragraph tell who you are, where you work, and the types of respiratory patients that you treat. If you are an educator, indicate how long you

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have been teaching and point out the complexity of respiratory therapy. In this paragraph indicate that you want your senators/representative to provide assistance on a critical Medicare patient care issue.

2. In the second paragraph – ***in your own words*** – indicate the following: *The Prospective Payment System for Medicare Skilled Nursing Facilities has dramatically reduced reimbursement for SNFs. Because of that reduction some (DO NOT SAY "ALL") SNFs feel the financial pressure to eliminate the use of qualified respiratory therapy providers. There are no minimum competency standards requiring that nursing home facilities assure that those providing respiratory therapy have the education, training, and competency to do so. Because of the financial incentives and the lack of competency requirements, patient safety is at risk.* You should state that credentialed respiratory therapists are the only care providers who undergo formal respiratory therapy education and VALID competency testing. (Please note: for those of you in states that do not have licensure indicate that even this minimal safety net is not there for the patient.) The more you can emphasize that patient safety has been compromised, the better. If you have any brief anecdotal stories providing examples of compromised patient care that you feel comfortable including, please do so.

3. Ask your senators/representative to consider sponsoring legislation that would require minimum competency standards for anyone providing respiratory therapy services to nursing home patients. Also request that they contact AARC Director of Government Affairs Cheryl West at (703) 548-8506 to set up a meeting to provide more information.

Please remember to:

- begin your letter with the following:
  Dear Senator/Congressman(woman)
  United States Senate/House
  (for the exact Washington, DC address of your senator(s)/representative please contact your local library or call me at 703-548-8506)
  Washington D.C. 20510 (Senate)
  20515 (House)
  ATTENTION: Health Legislative Assistant
- include your name, address, phone, FAX, and e-mail address
- include the two-page attachment titled "Assuring Patient Safety and Quality Care in Rendering Respiratory Therapy Services in Nursing Homes" (see following article) with your letter
- if it all possible, keep your letter to one page
- include "ATTENTION: Health LA" on both the letter and the envelope
- please send me a copy of your letter so that I can follow up with the health staff (mail to: 1225 King St., 2nd floor, Alexandria, VA 22314, or FAX to: 703-548-8499)

Through the AARC's efforts, Congress is aware that there are many flaws in the SNF PPS. With your help, we can focus their attention on respiratory therapy.

Thank you for your help. If I can answer any questions, or provide you with more information please do not hesitate to contact me. ■

Assuring Patient Safety And Quality Care in Rendering Respiratory Therapy Services in Nursing Homes

Editor's Note: The following "issue recap" was developed by the AARC for members to attach to their letters to their senators and representatives in Washington, DC regarding the SNF PPS.

Issue:

The implementation of a Prospective Payment System (PPS) for the Medicare Part A Skilled Nursing Facility (SNF) benefit has created a new environment for the provision and reimbursement of health care services to Medicare beneficiaries.

Nursing home providers have the responsibility to determine how the clinical needs of the patient will be met and which health care providers will be responsible in rendering the care. Because PPS will result in an overall reduction in SNF reimbursement, nursing homes will have a powerful financial incentive to utilize caregivers who are not qualified, by virtue of their education and competency, to provide respiratory therapy services. This situation will adversely affect both the quality of respiratory therapy services and the health outcomes of the Medicare beneficiary.

Situation:

Since November 1997, the AARC has been in discussions with HCFA to revise pertinent Medicare nursing home documents (the Resident Assessment Instrument Manual and the Survey and Certification Manual) as they pertain to the provision of respiratory therapy services. The AARC and HCFA have been unable to come to an agreement to include the following critical statement in the aforementioned documents:

"Respiratory therapy services may be provided by respiratory therapists or other health-care professionals who have been trained, educated, and have demonstrated competency in respiratory therapy services through a valid competency examination."

Respiratory therapy is a life-sustaining therapy. Therefore, respiratory therapy services rendered by individuals who have not documented their competency in respiratory therapy presents a very real danger to patients. Respiratory therapy rendered by individuals who do not have to document their competency can result in numerous negative clinical outcomes, such as:

1. providing services that may be inappropriate for the patient's condition,
2. providing unnecessary respiratory therapy services,
3. causing an increase in hospital readmissions due to pulmonary complications,
4. creating longer and more costly lengths of stay,
5. increasing morbidity, and
6. causing patient deaths.

Solution:

All persons providing respiratory therapy services to Medicare SNF beneficiaries should be required to document their competency.

Congress should require the following language to be included in both the Medicare Survey and Certification Manual and the Resident Assessment Instrument Manual:

"Respiratory therapy services may be provided by respiratory therapists or other health care professionals who have been trained, educated, and who have demonstrated competency in respiratory therapy services through a valid competency examination." ■

Florida Continues the Assault

The Florida Society for Respiratory Care (FSRC) is continuing to go on the offensive to support respiratory therapists employed in the SNF setting. Over the past few months, the FSRC has sent a series of letters to SNF administrators outlining the benefits that come from using RTs in this setting. The letters are being developed by the FSRC with the assistance of William Lindahl, CRTT, president of Nationwide Respiratory Services, Inc., who lectures and consults throughout the country on regulatory reform and its impact on health care, particularly respiratory care.

A summary of the society's initial efforts in this area appeared in the Nov.-Dec. issue of the *Bulletin.* In this issue, we feature the key points made in the latest letter, which basically offers administrators specific reasons why they should retain the services of respiratory therapists in their facilities despite the new prospective payment system (PPS).

Here are the points made in that letter:

When to retain respiratory therapists:

- RT services should be provided in your facility if an RT-type service could be required for at least five residents a month. RT-type services per RUGs categories include:
  - Residents requiring suctioning
  - Residents requiring tracheostomy care
  - Residents using oxygen
  - Residents receiving metered dose inhalers
  - Residents receiving HHN (hand held nebulizer or breathing treatments)
- Your RT services should:
  - Provide review of "Medical Review Policies"* by area intermediaries to protect claims submitted.
  - Provide a system of documentation that demonstrates criteria for coverage as identified by HCFA Publication 12 Section 230 & 214. Medicare did not change criteria for coverage of services; they did change reimbursement structure.
  - Provide services to all residents regardless of pay source.

Primary rationale for retention of RT services:

- RT is under nursing in three of the four RUGs categories for payment to help residents qualify for higher level of reimbursement.
- Documentation for care provided when under review must meet criteria for coverage set by Medicare and LMRPs* from area intermediaries.
- RT should be used to protect all residents from regression of cardiopulmonary system conditions. The government plans to impose monetary penalties (not yet released) for any readmissions of residents for the diagnoses for which they were admitted to facility.
- RT is the lowest cost ancillary service provider. For example:
  Unit Cost per discipline: Bill for month from provider hours of service provided divided by number
  residents treated = Unit Cost.
  Example: $10,000 (bill/mo.) divided by 500 hours of service divided by 20 residents treated = One Dollar ($1) per hour per resident
- RT will improve the status of higher acuity residents to facilitate better use of PT, OT, and ST.

Additional considerations:

- Look for capitated rates: Under PPS, RT is an overhead cost (no direct reimbursement), but RT protects the resident base at a lower cost than any other ancillary provider. Cost should be capped for better controls.
- Intermediaries will now be allowed to withhold payment to facilities that do not meet requirements for coverage set by their LMRP's and Medicare's criteria for coverage.
- Look for providers that will treat all pay sources for a flat rate.
- Avoid hourly rates because:
  - Hourly rates encourage providing services that are not needed.
  - Hourly rates force the provider to discriminate based on pay source.
  - Hourly rates encourage keeping the resident at higher frequencies of modalities and care.
- Avoid use of RT consultation services alone because:
  - All RT workload will remain on nursing staff.
  - Shared risk will only be provided for services billed.
  - All nursing staff would have to be trained to meet the requirements of LMRPs and Medicare's criteria for coverage (i.e., payment base is more at risk).
  - Early intervention for residents who regress or are at risk for readmission is not easily provided.

Very important consideration:

- Note that Medicare criteria for coverage remains unchanged per HCFA Pub 12 Section 23; i.e., "whoever is the most qualified to deliver the services should be providing the service to be eligible for coverage."

Look for a summary of the FSRC's next letter to SNF administrators, which will offer specific strategies for paying for respiratory personnel under PPS, in an upcoming issue of the *Bulletin.*

**"Medical Review Policies" are also frequently referred to as "LMRPs" - Local Medical Review Policies. If care provided in a facility fails to meet LMRP guidelines, intermediaries (insurance companies/other payors) may withhold funds to the facility.* ■

We Are Not Alone: *Other Organizations Are Supporting RTs in the SNF Setting*

The AARC clearly has a number of problems with the new skilled nursing facility prospective payment system (PPS) for Medicare beneficiaries. Top on our list, of course, is the fact that respiratory therapy, as one of the so-called "non-therapy ancillaries," is not adequately accounted for in the Resource Utilization Groups (RUGs) system.

But the AARC can't fight this battle alone, and luckily, it isn't having to. A brief look at what other groups and organizations had to say in their formal comments to the Health Care Financing Administration on the coverage of the non-therapy ancillaries in new SNF PPS should be heartening to RTs who are currently wondering if they have a future in this setting. Consider the following:

"We are concerned that the system does not make adequate allowance for non-therapy ancillary services," says the **National Association for Subacute Care** (NSCA). "We understand that only nursing time and costs were used to determine case mix. Nursing time does not, in many cases, directly correlate with the cost of ancillaries, such as respiratory therapy and pharmacy." Specifically, NSCA is concerned that the resource use for pulmonary and infusion therapy patients is not adequately reimbursed under the new system and that HCFA does not have the appropriate data to justify the inclusion of non-therapy ancillaries in PPS rates. "We recommend that HCFA develop the data to provide fair

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and adequate payment for these patients. HCFA should add new RUG categories as they have DRG categories for the Hospital PPS system and/or develop an outlier payment methodology."

"Perhaps the most problematic aspect of the PPS is its inadequacy in non-therapy ancillary costs," says the **American Health Care Association** (AHCA). "Such inadequacy is likely to lead to serious access problems for many Medicare patients who have high non-therapy ancillary needs . . ." AHCA is recommending that HCFA remove "the non-therapy ancillary costs from the current Resource Utilization Groups-III categories" and continue to pay for these services "on a reasonable cost basis outside of the PPS until critical research is completed and it is known how to pay for these services on a prospective case-mix basis."

"Inadequate . . . payment for non-therapy ancillary services" is a key problem with the new PPS, says the **National Association for the Support of Long Term Care** (NASL), and should be dealt with via a two-pronged approach. "Until at least January 1, 2000, the average per diem for non-therapy ancillaries . . . should be backed out of the nursing component and facilities should continue to receive cost-based reimbursements for their non-therapy ancillary costs as a direct cost pass-through." From there, the organization recommends that HCFA use data obtained from studies that are already underway to "revise the RUGs III categories to better reflect costs of non-therapy ancillary services" or create a "non-therapy ancillary case mix adjuster."

The **American Association of Homes and Services for the Aging** (AAHSA) believes the inadequacy of the RUGs III payment and insufficient coverage of the non-therapy ancillaries could be best dealt with through "an outlier provision, both because of the inherent, average nature of the RUGs III payments being used in facilities with relatively few Medicare patient days, and because of the extensive use of inadequately tested estimates and models to approximate resource use of different patients." AAHSA is calling for HCFA to immediately "pass through all non-therapy ancillary costs" until adequate cost and assessment data is collected to model the appropriate RUGs III amounts.

"Flat-rate reimbursement for non-therapy ancillary services may be inadequate to meet the needs of the residents," says the **National Citizens' Coalition forNursing Home Reform** (NCCNHR). "The rate allows no provision for very high cost procedures and treatments needed by some residents." The NCCNHR is concerned that some residents may not receive needed services or medications or may even have trouble finding a facility that will admit them due to their high non-therapy ancillary needs.

The **Health Industry Manufacturers Association** (HIMA) says that "failure to accurately reflect respiratory therapy and other ancillary services in the SNF payment rates raises concerns about inequitable reimbursement for and patient access to such services." Unless this issue is properly addressed, HIMA believes the system may discriminate against beneficiaries with special needs or rehabilitation potential. "HCFA should ensure that the SNF PPS relative payment levels provide for appropriate, specialized treatment, combined with medical advances made possible though technology innovation, that may directly impact life expectancy, as well as the quality of life for Medicare patients." ■

Subacute Care Section to Benefit from Electronic Mailing List

The Subacute Care Section now has an electronic mailing list that members can use to communicate with their colleagues around the country. For those of you who are unfamliar with the electronic "listserver," here's how it works:

You type and send one message to the mailing list and your message is automatically delivered to the emailboxes of all other section members who have signed up for the listserver. They, in turn, can answer your email by writing and posting a public response to the mailing list.

To access this new membership benefit, you must first "subscribe" to the list. However, do not misunderstand this term – you are not paying for a subscription in the typical sense of ordering a publication. (You have already paid for the privilege of accessing the listserver via the dues you pay to belong to the section.) All it means is that you are adding yourself to the mailing list of recipients.

Here's how to subscribe:

1. Sign on to AARC Online and then click on "Members Area" at the left of the opening screen. Then click on "AARC Specialty Sections." When prompted to put in your Name and Password, type in your AARC member number beside Name, then type in your member number again beside Password and click "OK." Note: If your membership number begins with a zero (e.g., 01234567), do not enter in the first zero. Begin entering in your membership number with the first non-zero number.
2. Click on "Subacute Care Section" and reenter your membership number as described above.
3. Follow the directions for subscribing to the listserver found on the section's site.

You must be a member of the section in order to participate in the discussions. If you are an AARC member but not a member of the section, you can join the section at any time using the online membership application found at:

https://www.respiratory.org/membership/active_form.html.

Just fill out the portion relating to Specialty Section membership. Alternatively, you may call the AARC Membership Department at (972) 243-2272 and join with a Visa or MasterCard. ■

Hot List Topics: *AARC Times* Wants Your Input

AARC Times is looking for clinical topics to feature during 1999 and is asking the members of our section to help come up with a "hot list." What are the key issues that we would like to see featured in the magazine over the coming year? Please take a minute to jot down the topics you would most like to read about in '99 and e-mail them to *AARC Times* Editor Marsha Cathcart at cathcart@aarc.org. If you would like to write on one of those topics, please let Marsha know and she'll get back to you with the details regarding article submission. ■

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