American Association for Respiratory Care's

Subacute Care Bulletin

April / May / June 2003

Notes from the Chair

by Melinda Gaylor, BSEd, RRT


Melinda Gaylor

It was with great excitement that I accepted the position of chair of the AARC's Subacute Care Section for 2003. I look forward to many rewarding challenges as the section moves forward this year, and I assure you I will be focusing on the same initiatives as our previous chair, Carol Dague, who unfortunately had to resign due to work commitments.

These initiatives include:

- Increase awareness of opportunities for respiratory therapists in post-acute care environments.
- Increase membership of the section.
- Facilitate regulatory changes that affect the post-acute arena and practices of respiratory care.
- Provide effective medical direction resources for the post-acute arena.
- Integrate post-acute care into respiratory care education programs.

As a member of the section, your feedback is essential in facilitating these initiatives. I look forward to working with each of you over the coming months. Please do not hesitate to contact me with suggestions, comments, or concerns.

I would also like to thank George Gaebler for taking on the position of Bulletin editor. I want to encourage each of you to consider writing an article for these pages to share your success stories or explore specific areas of subacute care. George's contact information appears on page two, along with my own.

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2003 Cancer Facts and Figures

The American Cancer Society released its Cancer Prevention and Early Detection Facts and Figures 2003 in January, focusing on estimates of new cancer deaths for the current year. The report, which also includes a section on smoking cessation, offers data on national and state tobacco use, nutrition, physical activity, and use of cancer screening tests.

Consider these statistics from the reports:

- According to the latest data, the death rate for all cancers combined is about 30% higher in African-Americans than in white Americans.
- The five-year relative survival rate for all cancers combined (the percentage of people with cancer who do not die from the disease within five years) is 62%.
- Lung cancer will remain by far the number one cause of cancer death in the U.S., with an estimated 157,200 deaths expected in 2003. Breast cancer is expected to kill 40,200 people.
- Incidence and death rates from lung cancer continue to decrease in men and have leveled off in women. Despite the increasing incidence of breast cancer, the death rate continues to fall. Death rates from prostate cancer have decreased since the early 1990s, but rates in black men remain more than twice as high as rates in white men.
- In the U.S., cigarette smoking alone causes about 30% of cancer deaths. An estimated $157 billion in annual health-related economic losses are attributable to smoking. ◆

Study: Health Care Spending Larger Part of Economy Despite Slower Growth

A study in the journal *Health Affairs* forecasts a slowdown in national health spending growth, reflecting slower projected Medicare and private personal health spending growth.

The authors project national health spending will outpace economic growth through 2012, with the health share of the gross domestic product expected to increase to 17.7% in 2012, up from 14.1% in 2001. In a commentary on the report, American Hospital Association Vice President for Policy Don May notes, "As baby boomers age, more Americans will use health services. Health care is an important investment in the well-being of our nation."

May also attributed increased spending on health care to rising costs of labor, prescription drugs, and new technology. ◆

NASL: Patients Benefit From CMS Postponement Of $1,500 Therapy Cap for Medicare Part B

The National Association for the Support of Long-term Care (NASL) called the decision by the Centers for Medicare and Medicaid Services (CMS) to postpone the outpatient Part B $1,500 therapy caps a victory for vulnerable patients in need of special care. The caps, which were scheduled to go into effect on January 1, would have adversely impacted patients via an onerous, arbitrary, and unworkable standard, says the organization.

Tracy Gregg, a member of the NASL Board of Directors, states, "Many patients would exceed this cap for medically necessary treatments and may have been forced to either pay for therapy out of their own resources or limit access to this essential medical benefit. The CMS action is a clear win for patients who can now receive therapy in the amount specified by their physician, and CMS is to be congratulated on taking this pro-patient action."

A coalition of beneficiary and other provider organizations is working to encourage

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NOTES FROM THE CHAIR

Interesting reading gleaned from the headlines

Following this, you'll find several pertinent articles illustrating a variety of issues in health care and health care spending that should be of interest, regardless of what may be happening in your place of employment. These articles run the gamut from demographic realities to the views of other organizations on spending patterns impacting health care as a whole, and specifically, the subacute area of practice. Please take a few moments to read the articles, then enjoy George's insight into their implications for subacute RTs in the commentary that follows. ◆

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AHCA Opposes MedPAC Recommendations on SNF Funding

The American Health Care Association (AHCA) expressed outrage regarding the decision by the Medicare Payment Advisory Commission (MedPAC) to ignore disturbing evidence clearly showing long-term care patients will fall further behind in access to quality care if funding for skilled nursing care is cut further.

"The negative impact on patients and caregivers from the collective problems we have outlined - and that have been ignored - are now manifesting themselves in headlines across the nation regarding nursing home closures, more bankruptcies, and elderly and disabled patients being forced to move far away from family and friends," states Charles H. Roadman II, MD, president and CEO of AHCA. "The MedPAC recommendations are a tremendous disappointment, and do not reflect or address what is occurring to elderly and disabled patients in our states and local communities."

Medicare funding for skilled nursing care was reduced by 10%, or $1.8 billion per year, last October, and funding may be cut an additional 19% this year if the Bush Administration doesn't delay implementation of the reduction. MedPAC voted to recommend that Congress eliminate the annual inflation adjustment for skilled nursing facilities in 2004. MedPAC staff estimated that this would reduce funding for care by an additional $200-$600 million in 2004 and up to $5 billion over the next five years.

These additional cuts come at a time when deficit-ridden states are slashing their Medicaid rates - which already fall short of covering the acknowledged cost of providing care. A recent survey by the Kaiser Commission on Medicaid and the Uninsured found that 49 out of the 50 states will act to reduce their Medicaid spending this year, with 37 planning on reducing or freezing the amount of funding for nursing care. A 2000 study by the accounting firm BDO Seidman found that nursing facilities provided $3.5 billion in unreimbursed care for Medicaid patients in 2000, and concluded this amount "will significantly increase" this year due to the states' fiscal crisis - the most severe since World War II.

Dr. Roadman says MedPAC's recommendations are flawed based on the following arguments:

- Due to the current Medicaid under-funding crisis, in conjunction with the recent $1.8 billion cut to Medicare, total operating margins for skilled nursing facilities are currently minus 2% - according to MedPAC's own data. This has limited the skilled nursing community's ability to access capital and upgrade infrastructure to meet certain increases in future demand for care, and will negatively impact quality.
- The Centers for Medicare and Medicaid Services (CMS) has acknowledged that errors in its market basket forecast have caused inflation to be understated by 3.73% over the past three years.
- The Department of Health and Human Services (HHS) doesn't have a rational methodological framework to determine how best to redistribute the 6.7% adjustment to the 14 rehabilitation patient payment categories to other payment categories.

"When it comes to making important public policy recommendations that truly impact people's lives, it is inconceivable that baseline data used to reach conclusions about the sufficiency of Medicare funding is two years old - and ignores the dangerous, obvious, and statistically undeniable trends regarding Medicare-Medicaid cross-subsidization now unfolding right before our eyes," states Dr. Roadman.

Mary K. Ousley, AHCA chair, says, "These recommendations are ill-advised and must not be adopted. They ignore and perpetuate the crisis in long-term care that is being felt in every state in the union and will soon be felt by nearly every family in America. Homes are closing; many firms that operate them have filed for bankruptcy protection; services are being cut back. This follows a pattern of government turning a blind eye to an obvious problem that we and others have been pointing out for months. The government has to face the fact that it is the purchaser of almost all nursing home services; it demands that quality be first rate, as it should, and the reality is that quality care cannot be provided for less than cost. Rome is on fire; Nero is fiddling; and the old, the frail, and the disabled are paying for it." ◆

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NASL: PATIENTS BENEFIT FROM CMS POSTPONEMENT OF $1,500 THERAPY CAP FOR MEDICARE PART B

Congress to repeal the $1,500 therapy cap. Data have shown one in seven Medicare Part B patients will exceed the caps if they go into effect. In June 2002 the U.S. House of Representatives passed legislation to extend the moratorium on enforcement of the caps until December 31, 2002. The Senate has not acted, despite the fact that 25 Senators co-sponsored S-1394, sponsored by Senator John Ensign (R-NV).

CMS has released a program memoranda indicating the therapy caps will not be implemented until July 2003, when they are able to track beneficiary charges as required under the Medicare statute. The agency has further indicated that the caps will not be applied retroactively; therefore, neither providers nor beneficiaries will be required to track charges until the caps are actually implemented. ◆

A Commentary

by George Gaebler, MS Ed, RRT, FAARC

The articles leading up to this commentary reflect just some of the current events that have been covered recently in various publications, on the web, and on news programs.

For many years the AARC has helped fund research activities aimed at demonstrating the effectiveness of respiratory therapists in the provision of care. These studies show that the use of the respiratory therapist is more cost effective than alternatives that might be put in place to deal with the opposing realities described above. The Muse & Associates Study sponsored by the AARC specifically showed, using CMS statistics for actual costs of care, that RTs do provide the most cost effective care in subacute settings.

The above articles came from our new section chair, Melinda Gaylor, who researched recent publications for items related to subacute care and sent them on to me for inclusion in the *Bulletin*. I couldn't help noticing that most of the subject matter relates to many of the things the AARC does for its members on a daily basis. These include advocacy for the profession in Washington and through information sharing with the states via the Political Advocacy Contact Team (PACT). In the last year, the PACT have been engaging patients like Nick Dupree to venture to state and local legislators' offices to put a real face on the conflict between growing demand and attempts to slow growth in expenditures. It is clear that real patients with real needs - like Nick Dupree - can cause a change in policy, even with the opposing forces we face.

The AARC's efforts to highlight RC Week provide our profession with a golden opportunity to highlight our value to the system. It is time for rank and file RTs, who care for patients and know that they need access to care and support through reimbursement, to impact future funding by introducing their legislators to those patients and educating them about their needs. We, in concert with our patients, can assure that our expertise in respiratory care will be available in the future. We cannot wait for someone else to do what needs to be done.

I have spent many years working throughout the entire continuum of care, from hospital to nursing home to home care. When reimbursement was cut, many therapists lost their positions in subacute and home care settings. Now we are poised on an unprecedented brink in health care, with the opportunity to really make a difference. Those of you reading this article need to pull your colleagues who may have dropped their AARC membership due to the reimbursement cuts back into the fold. Through personal advocacy and the support of the 15 million people we care for, we can send a powerful message to our legislators. But we will have to make it happen, because many of our patients will only step up to "tell their story" if we help them get there and back safely. They will be our best advocates in the reimbursement arena. Our patients depend on us for their continued health and well being, just as we depend upon them for our future enhanced place in health care. ◆

In the "Nick" of Time

EDITOR'S NOTE: The following article is being reprinted from the April issue of *AARC Times*.

A couple of years ago, AARC members were asked to sign a petition sponsored by a young man from Alabama who was fighting to have his Medicaid home care benefits extend beyond his 21st birthday.

Nick Dupree, who suffers from a rare form of muscular dystrophy that has left him a quadriplegic and on a ventilator, knew his benefits would run out on February 23 of this year, thanks to a provision in the state law that only provides in-home care for disabled children. Since he requires 16 hours of home care services a day, the alternative would be institutionalization in an out-of-state nursing home capable of handling his special needs. He'd have to leave his family and drop out of Spring Hill College in Mobile.

So when he turned 19, he launched "Nick's Crusade," a massive effort aimed at creating a federal waiver program for himself and other disabled young people facing the age 21 cutoff. Fred Hill, MA, RRT, professor of respiratory care at the University of South Alabama and Dupree's home care therapist, has been one of many folks who helped him along the way.

Now it's all paid off. "Nick had a major victory on Feb. 11," reports Hill. "The newly created federal waiver program went into effect Feb. 22 - the day before Nick turned 21." As it turns out, Nick was working not just for himself and other disabled children, but also for his younger brother, Jamie, who suffers from the same disease and was facing the same fate in a couple of years.

Hill first became acquainted with Nick in 1986 when he decided to go to work for a local DME on a part time basis to keep his RT skills current and learn more about the newly emerging opportunities in home care so he could pass the information on to his students. He was assigned to care for two-year-old Jamie, who had required mechanical ventilation since the age of 10 months. At the time, four-year-old Nick was still able to move about and breath on his own. Complications from back surgery in 1991, however, left him in the same condition as his brother, and Hill began to care for both boys.

When Nick launched his crusade, Hill put him in touch with the respiratory care community, arranging for him to speak at a state society meeting and taking his petition to the AARC for support from therapists across the nation. He also testified on Nick's behalf before a state senate health committee in Montgomery.

He still serves as both boys' home care RT today, and continues to be amazed at their ability to cope with the limitations life has handed them and fight for the right to live at home. "It is hard to put in a few words how important this is. It just has too much to do with the human condition, a belief in justice, the right to life, liberty, and the pursuit of happiness - you know, the kind of stuff we believe led to the founding of our nation." ◆

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