



Subacute Care

Bulletin

Sept./Oct. '98

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**NASL Study Says
Therapy Cap Will Harm
One in Seven**

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FYI...

American Association
for Respiratory Care

Legislative Alert: Serious Challenges Require Immediate Action

Those of us working in subacute care and skilled nursing facilities are well aware of the serious challenges ahead for our patients and our profession within the interim Prospective Payment System (PPS) for Medicare Part A SNF services.

Our problems under PPS can be traced back to flaws in the methodology used to establish many of the components of PPS. HCFA did not accurately account for respiratory services as they devised their new payment system of patient categorization. For payment calculation purposes, HCFA elected to place respiratory therapy as a component in the non-therapy ancillaries category, which also includes pharmacy, IV therapy, orthotics, and prosthetics, among others.

As part of the AARC's rebuttal to the SNF PPS regulations, we are working in a coalition with other SNF providers to lobby Congress to pass emergency legislation requiring HCFA to provide the non-therapy ancillaries a temporary exemption in the PPS payment. This extension will be termed a "pass-through," and would be effective from 18 to 24 months, until further studies can more accurately determine appropriate payment levels. The Senate is taking the lead on this issue, and the active support of respiratory therapists working in subacute care and skilled nursing facilities is absolutely critical in convincing them of the need for such legislation. Therefore, we are asking you to send letters to your U.S. Senators emphasizing that:

- You are a respiratory therapist working with SNF patients at (Name of Your Facility). Include a brief description of what you do and who your patients are.
- You have grave concerns over the current Prospective Payment System for Medicare Part A SNF services.

- Respiratory therapy should never have been included as a "non-therapy ancillary." Rather, it should be recognized in the more appropriate category of "therapy."
- The Senate should require HCFA to create a temporary, 18-24 month pass-through for the payment of non-therapy ancillary services under the SNF PPS. Be sure to note that an economic study has documented that the database used by HCFA is flawed, and the only way to have accurate data is to do further analysis and study.
- Without a pass-through, facilities that are treating respiratory therapy patients, especially those with high acuity, will not receive appropriate reimbursement. The quality of, and access to, respiratory therapy will be diminished, thus undoubtedly forcing patients to receive care in the higher cost acute care setting.

Points to remember

- Make it short—two pages or less.
- Make it legible.
- Include your name and address.
- Make it as original as possible. Form letters don't work.
- If you don't know your senators' names, call your local library or look on the Internet at:
<http://www.senate.gov/senator/index.html>.

Follow this address format:

Senator _____
United States Senate
Washington, DC 20515
Dear Senator _____:

It is particularly critical that letters be received by Senator Charles Grassley (IA), Senator Edward M. Kennedy (MA), and Senator William H. Frist (TN). (Source: AARC) ■

A Multi-Pronged Attack

Ever since provisions for a prospective payment system for SNFs were outlined in the Balanced Budget Act of 1997, the AARC has been hard at work on strategies designed to strengthen the position of respiratory therapists in these facilities. In addition to calling for emergency “pass through” legislation for the non-therapy ancillaries (see previous article), our many-pronged attack has included:

- Working with HCFA to update seri-

ously imprecise definitions of respiratory therapy in the RAI manual, as well as advocating a provision that would require providers of respiratory therapy services to document competency in the services they provide.

- Seeking legislation to require HCFA to include respiratory therapy services as part of the rehabilitation therapy category in the PPS system.
- Assuming the lead in organizing a coalition of key players in the subacute

industry in order to coordinate an effective response to the flawed PPS regulations. This group includes major skilled nursing facility providers and associated professional organizations.

- Commissioning an economic analysis of the HCFA database that resulted in confirmation of our contention that respiratory therapy services are under-recognized in HCFA’s cost calculations. (Source: AARC) ■

HCFA Issues New Report on Nursing Homes

A new government report on the impact that toughened regulations are having on the nation’s nursing homes reveals that the health and safety of America’s more than 1.6 million elder-

ly nursing home residents is improving.

According to the report, the overuse of anti-psychotics is down from about 33% before nursing home reform was implemented to 16% now. Use of antidepressants is up from 12.6% to 24.9%, a rate more commensurate with the estimated nursing home prevalence of depression, and the inappropriate use of physical restraints is down, from about 38% to under 15%. Inappropriate use of indwelling urinary catheters is down nearly 30%, and the number of nursing home residents with hearing problems who receive hearing aids is up 30%.

While applauding these improvements, the Health Care Financing Administration (HCFA) report also highlights several areas that still need greater attention. Specifically, HCFA is concerned that state-run nursing home inspections are too predictable, often occurring on Monday mornings and rarely on weekends or during evening hours, allowing nursing homes to prepare for inspections. In addition, several states rarely cite nursing homes for substandard care, an indication that their inspections and enforcement may be inadequate, and nursing home residents continue to suffer unnecessarily from clinical problems—such as pressure or bed sores, malnutrition, and dehydration—which can be prevented with proper care. Residents also continue to experience physical and verbal abuse, neglect, and misappropriation of residents’ property.

In order to rectify these problems, HCFA is taking steps on several fronts to toughen enforcement of nursing home safety and quality regulations.

New regulatory measures include the following:

- Nursing homes found guilty of a second offense for violations harming

residents will have sanctions imposed and will not receive a “grace period” that allows them to correct problems and avoid penalties.

- HCFA will permit states to impose civil monetary penalties for each instance of serious or chronic violation. Until now penalties have been linked only to the number of days a facility was out of compliance with regulations.
- Nursing home inspections will be conducted more frequently for repeat offenders with serious violations without decreasing inspection frequency for other facilities.
- Nursing home inspection times will be staggered, with a set amount to be done on weekends and evenings.
- Federal and state officials will focus their enforcement efforts on nursing homes within chains that have a record of noncompliance with federal rules.

To target states with weak inspection systems, HCFA will:

- Provide additional training and other assistance to inspectors in states that are not adequately protecting residents.
- Enhance federal review of the surveys conducted by the states and implement standard evaluation protocols in every state this fall.
- Ensure that state surveyors enforce HCFA’s policy to sanction nursing homes with serious violations and that sanctions cannot be lifted until after an onsite visit has verified compliance.
- Terminate federal nursing home survey funding to states that fail to adequately perform survey functions or fail to improve inadequate survey systems. HCFA will then contract

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with other entities to conduct nursing home survey and certification activities in those states.

HCFA will also:

- Step up its review of nursing homes' ability to prevent bed sores, dehydration, and malnutrition. Nursing homes with patterns of serious violations will be sanctioned. HCFA also will work with the Administration on Aging, the American Dietetics Association, clinicians, consumers, and nursing homes, to develop a repository of best practice guidelines for residents at risk of weight loss and dehydration.
- Combat resident abuse by having state inspectors review each nursing home's system to prevent, identify, and stop physical or verbal abuse, neglect, and misappropriation of resident property. A description of each nursing home's abuse prevention plan will be shared with residents and families. HCFA will also ask states to direct nursing homes to inquire about criminal convictions when interviewing potential personnel.
- Prosecute egregious violations by working with the HHS Inspector General and the Department of Justice (DOJ) to ensure that state survey agencies and others refer appropriate cases to the DOJ for prosecu-

tion under federal civil and criminal statutes, and work with the Office of the Inspector General (OIG) to conduct training for and provide technical assistance to federal survey and certification staff and HCFA contractors on how to make appropriate referrals to the OIG.

- Publish individual nursing home survey results and violation records on the Internet to increase accountability and flag repeat offenders for families and the public.
- Continue development of Minimum Data Sets to collect information on resident care that can be analyzed over time to identify potential areas of unacceptable care and be used to assess nursing home performance in such areas as avoidable bed sores, loss of mobility, weight loss, and use of restraints.

In addition to these administrative steps, HCFA will ask Congress to:

- Establish a national registry of nursing home employees convicted of abusing residents and require nursing homes to conduct criminal background checks on all potential personnel.
- Allow more types of nursing home employees, with proper training, to perform crucial nutrition and hydration functions.
- Reauthorize a strong long-term ombudsman program through the

Older Americans Act, administered by the Administration on Aging, that would provide information about poor-quality nursing homes and abuse or neglect of patients.

- Establish user fees for Medicare providers and suppliers requesting participation in Medicare, both for initial surveys and for recertification surveys, that would reflect the unit cost of a survey and the appropriate and reasonable costs incurred by state survey agencies for fee collection and associated activities.

Finally, at Congress' request, the HCFA report also evaluated whether private accreditation of nursing homes would be preferable to the current system of public accreditation. HCFA secured an independent evaluation by Abt Associates to assist in preparation of that portion of the report.

The report concludes that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey process is not effective in protecting the health and safety of nursing home residents. According to Abt Associates, granting "deeming" authority to JCAHO would place nursing home residents at serious risk. For example, in more than half of 179 cases where both HCFA and JCAHO conducted inspections of the same nursing homes, JCAHO failed to detect serious problems identified by HCFA. ■

NASL Study Says Therapy Cap Will Harm One in Seven

Editor's Note: Respiratory therapists aren't the only providers having difficulties with the new SNF PPS. Physical therapists, occupational therapists, and speech/language pathologists also believe their services may not be adequately covered under PPS. The following article outlines a new study suggesting that the coming therapy cap will have a major impact on those services as well.

An analysis of 1996 federal health data conducted by the National Association for the Support of Long Term Care (NASL) has found that about one in seven Medicare beneficiaries requiring rehabilitation services will have coverage for these services arbitrarily cut off due to a provision in

the Balanced Budget Act of 1997 calling for a \$1,500 annual cap, or limitation, on therapy. The provision, which is scheduled to go into effect on January 1, will make beneficiaries responsible for expenditures exceeding the coverage cap.

Approximately 5.6 million Medicare beneficiaries received physical therapy, occupational therapy and speech-language pathology rehabilitation services during 1996. Most of these beneficiaries were recovering from catastrophic conditions such as stroke, hip fracture, or other devastating conditions. The NASL analysis used federal government data to track the flow of beneficiaries through the care delivery system. Approximately 2.1 million beneficiaries required extensive rehabilitation services beyond a first encounter. Projections based on data from the Medicare 5% Public Use File show that

about one in seven Medicare beneficiaries who need rehabilitation services outside a hospital setting are likely to exceed the \$1,500 cap in 1999. The study also showed that:

The data, analyzed by age, medical condition, and setting, confirm that the oldest and sickest beneficiaries are most likely to require more Medicare Part B therapy services than those covered under the new law.

The data documents that the arbitrary cap would significantly limit clinical services available for victims of stroke or hip injuries, many of whom would require treatment in different settings.

For individuals requiring extended recuperative nursing home stays, nearly two-thirds of medically necessary treatments would be curtailed. Half of

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all such residents receiving rehabilitation services would be impacted.

The impact would be most devastating for those who have multiple medical incidences during a year. As enacted, the cap would be a cumulative annual limit restricting Part B therapy services in all but the hospital outpatient setting.

The report, *An Analysis of Rehabilitation Services "Flow" Patterns and Payment by Provider Setting for Medicare Beneficiaries*, 1996, reinforces findings released last fall by NASL using 1994 HCFA 5% Public Use File data. Both studies were conducted by Muse & Associates, a leading Washington, DC, health care data analysis firm.

The findings are also consistent with those released by the Medicare Payment Advisory Commission in their June report to Congress, *Context for a Changing Medicare Program*. This government advisory agency estimates that one in ten Medicare beneficiaries receiving rehabilitation services would have exceeded the cap if it were in place during 1996.

NASL Executive Vice President Peter Clendenin stated, "This data confirms the major cut in benefits which Medicare beneficiaries will receive. Unless Congress takes action to change this immediately, hundreds of thousands of Medicare beneficiaries will not receive the cost effective and important therapy services they need. Because this policy was enacted with no hearings, and based upon only min-

imal data, it points out the problems associated with enacting law when you don't know what the effects will be."

Clendenin went on to point out that NASL and a coalition of provider and consumer groups are working with Congressman John Ensign (R-NV) and Senator Charles Grassley (R-IA) to enact legislation to remedy this major problem. If the legislation is adopted this year, many of the problems associated with unserved beneficiaries will be alleviated.

NASL is a non-profit organization representing ancillary providers to the post-acute industry. For questions or a copy of a detailed summary of the report, please contact NASL at (703) 549-8500. (Source: NASL Press Release) ■

FYI . . .

Impaired breathing may raise stroke risk—but marriage could lower it

High blood pressure, prior stroke, and having an irregular heartbeat are all well-established risk factors for stroke. Now Australian researchers have added another risk factor to that list: impaired breathing. Their study of the hospital and death records of 2,805 men and women over the age of 60 found that those whose peak expiratory flow was most impaired by chronic bronchitis had a 77% higher risk for having a stroke when compared to those whose breathing was the least impaired.

"The relationship between impaired peak expiratory flow and ischemic stroke has not, to our knowledge, been previously reported," say the authors. "A suggested link between inflammation and atherosclerosis is very topical, especially with recent research on the link between respiratory infection and heart disease. Our data allows the possibility of speculation and extrapolation, but more specific research needs to be done on this link."

Another interesting finding in the study was that marriage may protect against stroke. Investigators found that people who were married had a 30% lower risk of stroke, and married women, in particular, had a 46% lower risk.

The study was published in the June issue of *Stroke: Journal of the American Heart Association*. (Source: AHA Press Release)

Alendronate effective against steroid-induced osteoporosis

Steroid-induced osteoporosis is one of the most feared complications of chronic steroid use and often keeps patients from taking the medications. University of Iowa researchers, however, have found that steroid-induced osteoporosis can be effectively prevented and treated with oral alendronate.

Along with other members of the Glucocorticoid-Induced Osteoporosis Intervention Study Group, they conducted two randomized trials of alendronate, the first in 232 U.S. patients

and the second in 328 patients from 15 other nations. The subjects, who continued to take at least 7.5 mg/day of prednisone or an equivalent drug, were given either a 5 mg/day dose of alendronate, a 10 mg/day dose, or placebo for 48 weeks. All patients also took calcium and vitamin D supplements.

Results showed that both doses led to significant increases in average bone mineral density at the lumbar spine, femoral neck, and trochanter. The larger dose also increased total-body bone density and was more effective in postmenopausal women who were not on estrogen-replacement therapy. Improvements were noted irrespective of age, sex, the current corticosteroid dose, previous corticosteroid therapy, type of disease being treated with corticosteroids, or bone mineral density at the lumbar spine at the start of the study. Although upper gastrointestinal problems were significantly more common at the higher dose of alendronate, few of the effects were serious. (Source: N Engl J Med 1998; 339:292-299) ■

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