

## HR 2619 – Medicare Respiratory Therapist Access Act

**The information provided below is based on our best knowledge of the Medicare statute, regulations and other policies. However, it is important to note that only CMS can determine how the benefit will be implemented if Congress enacts the legislation.**

### **What does HR 2619 do?**

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**HR 2619, the Medicare Respiratory Therapist Access Act**, amends Medicare Part B to cover “pulmonary self-management education and training services” when furnished by qualified respiratory therapists (RTs) in the physician practice setting for Medicare beneficiaries who have been diagnosed with COPD, asthma, pulmonary hypertension, pulmonary fibrosis and cystic fibrosis. The RTs would work under the direct supervision of the physician and the physician would bill Medicare for the RTs’ services. To qualify, the RT must hold a “registered” credential and have at a minimum a bachelor’s degree or other advanced degree in a health science field appropriate to the services RTs provide. In other words, a degree in English Literature or Marketing, for example, would not qualify. RTs can be part-time or full-time employees of the physician practice or be contracted to provide the services; however, RTs cannot start their own independent practice.

### **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. It could also cover education about a patient’s oxygen system and teaching the patient how to make sure their oxygen saturation levels are adequate. Smoking cessation counseling most likely would not be covered as part of the self-education and training because it is a separate benefit under Medicare with separate codes. That is not to say that RTs would not be able to provide the counseling. They can do so under the general “incident to” rules.

### **Aren’t self-management services covered now?**

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Medicare covers self-management outpatient training as a separate category only for diabetes patients under a distinct benefit passed by Congress over a decade ago. Recently, CMS has begun to include self-management as part of new care coordination services that are bundled into transitional care and chronic care management services, but these services have limited time periods for coverage and do not focus specifically on the needs of pulmonary patients and the variety and complexity of devices and medications used to treat their chronic lung disease. That is why we need to push to get sponsorship of **HR 2619** and a companion bill in the Senate. If CMS follows the precedent for diabetes self-management training, they will most likely establish two new G codes just for “pulmonary” self-management education and training”.

## **Why did AARC single out pulmonary self-management education and training over other RT services?**

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The AARC wants to position RTs to be at the forefront of initiatives that improve quality care and keep pulmonary patients healthier. The Accountable Care Act is changing the paradigm in how health care services are being delivered. Keeping Medicare patients from being readmitted within 30 days after they have been discharged from an inpatient stay is one of the most important initiatives underway. This is especially true since COPD will be added to the list of conditions subject to penalties under the Hospital Readmissions Reduction Program come October 1, 2014.

Patient self-management has been getting attention of late. Making self-management an integral part of the health care system for individuals suffering from multiple chronic conditions by 2020 is a goal of the Department of Health and Human Services, since these patients are among the most costly. It is also supported as a way to reduce hospital readmissions by the Medicare Payment Advisory Commission, an independent group of experts who advise Congress on various Medicare payment strategies. Studies also show that self-management education can reduce urgent care visits and hospitalizations.

Self-management education helps patients to recognize and reduce the symptoms and triggers of their chronic lung disease which can lead to reduced exacerbations and lower the cost of acute care. Medicare patients who properly self-manage their chronic lung disease working with RTs can slow their disease progression and improve health status. It is important that RTs bring that expertise to physician practices.

## **Why is AARC setting specific RT qualification standards?**

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Non-physician health professionals who are currently covered under the Medicare law such as physician assistants, nurse practitioners, clinical nurse specialists, physical therapists, 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. 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.

## **I work in a physician practice now and don't meet the criteria under HR 2619. Can I lose my job?**

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

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

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HR 2619 takes the guesswork out of whether the physician will get paid for the RT's services because self-management education and training will be a covered service. This is a big

incentive for physicians since in the past, under the current “incident rules”, physicians have been reluctant to hire RTs because they are uncertain of reimbursement. 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.

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.

### **Do we have an idea what the bill will cost?**

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Most legislation introduced by Congress requires a cost estimate from the Congressional Budget Office (CBO) in order to move it forward. So, when talking with Members of Congress or their staffs, one of the primary questions you will hear asked about HR 2619 is “How much will it cost?” To get an idea of what that answer would be, AARC commissioned an independent health care firm to develop a “CBO-like” cost estimate. This effort is designed to help with sponsorship on the Hill. Regardless of what the independent analysis shows, we expect Congressional staff will still want a CBO score in order to move the legislation forward.

The independent cost analysis estimates **HR 2619** would result in an increase to Medicare of \$245-\$500 million over a 10-year period from 2014 through 2023, or \$25-\$50 million annually, which in federal budget terms is not a significant number. The estimate is based on the percentage of eligible Medicare beneficiaries who successfully self-manage their disease working with RTs. Since it is unlikely that 100% of all Medicare patients will qualify for self-management or be able to successfully self-manage their disease (the \$500 million estimate), we are using the cost estimate of \$245 million over a ten-year period. This cost is based on 70% of Medicare beneficiaries being able to self-manage successfully which is a more realistic goal.

### **Do we have a “pay for” if asked by Congressional staff?**

The AARC is continuing to pursue an appropriate “pay for” that will offset the estimated cost of the bill. The one we suggested to the bill’s sponsor did not work out as we had hoped. According to the independent cost analysis commissioned by AARC, it is possible the estimated cost of the bill could be offset by savings that are likely to occur between 2014 and 2023. For example, it is reasonable to expect that if one-half of one percent of ER visits for the population served by **HR 2619** were avoided due to self-management skills taught by RTs, the costs could be totally offset. If 24 percent of patients who had an ER visit and a claim for oxygen improved their oxygen utilization and adherence to inhaled medications as a result of self-management, it may also likely result in a total offset of the costs associated with implementation of **HR 2619**. While this is good information to pass on to Congressional leaders, unfortunately CBO will not accept future savings as a pay for if they are asked to estimate the cost of the bill.

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

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It is important for you to support HR 2619 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 **HR 2619** 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. HR 2619 impacts respiratory therapists who work primarily in a physician practice. Why should I care and work for this?**

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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 practice with greater independence. If enacted, **HR 2619** will do just that.