
Weighing in on National Pulmonary Rehabilitation Coverage

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Abstract

The purpose of this analysis is to look at what impact a national pulmonary health coverage bill would have on patients, insurance providers, hospitals, and allied health workers. National coverage would extend coverage availability to all underserved areas where coverage is currently unavailable; however at a huge cost. There are millions of individuals that could benefit from pulmonary rehabilitation services, but under the proposed legislation for national coverage many programs would have to close the doors because of low reimbursement and many hospitals will be hesitant to start new programs. The current program operates on a fee for service basis where all therapies rendered are line item billable. The proposed legislation could package all services into a fee per day payment system. This would force programs to operate using skeleton staff and stray from the multidisciplinary approach that is most effective in treating pulmonary patients.

INTRODUCTION

Pulmonary rehabilitation is primarily conducted on an outpatient basis in acute care facilities throughout the United States. The purpose of these programs is to teach patients with chronic lung diseases to cope with their illness. The most effective method of delivering care for these patients is a multidisciplinary approach to include occupational therapy, physical therapy, respiratory therapy, and a psychosocial component. Programs that incorporate all of these elements have much better outcomes than those that only use select disciplines.

Many lobbyist organizations have been struggling for national pulmonary rehabilitation coverage for over 20 years. Congress in the past has terminated legislation in the past many times before a bill could ever make it to the floor. However, with the rise of health care costs due to pulmonary problems and the promise from experts that pulmonary rehabilitation could reduce these costs significantly it appears that congress may be listening. Medicare pays more for acute care stays due to exacerbation of chronic pulmonary conditions than all other insurers combined. National Medicare policy coverage for pulmonary rehabilitation could drastically improve the quality of life for pulmonary patients, as well as, save millions in health care expenses for the Medicare system.

REVIEW OF LITERATURE

Studies have shown that patients who have chronic pulmonary disease and attend pulmonary rehabilitation programs have much improved outcomes over those that do not. Their quality of life is much greater. They can participate in activities of daily living with much more independence. They have a greater likelihood of being socially active because of better physical health. They take fewer medications and require fewer hospitalizations to manage their disease. However, pulmonary rehabilitation is still a luxury service to some depending on where they live geographically (Federal Government Affairs, 2006).

CURRENT POLICY

A battle has been looming with congress for over 20 years for a clear definition of policy coverage for Medicare pulmonary rehabilitation coverage. The current coverage is scattered among territories that state governments contract out to write policies for coverage known as Fiscal Intermediaries (FI). Many states will adopt the policy of others and join their territory of coverage and contract the same FI to write their policies. For example, West Virginia and Virginia have the same FI, United Government Services that drafts all of their coverage plans. Both of these states provide liberal coverage and a multidisciplinary plan. All hospitals that operate pulmonary rehabilitation programs within these states must operate under the Local Medical

Review Policy established by the FI in regards to Medicare billing. The LMRP dictates that the program must have a medical director, all services must be medically necessary, performed by a multidisciplinary team operating off a treatment plan, and must stop as soon as a patient is able to perform these services on their own in an unskilled environment or a predetermined number of sessions have been reached whichever comes first. This type of program works very well for most Medicare recipients, however; there is admission criteria and a standard of care that must be maintained (Advocacy, 2006).

PROBLEM WITH EXISTING POLICY

Other states currently have no LMRP in place for pulmonary rehabilitation, which means there is no coverage for patients that require these services. These states have elected not to provide for the needs of their pulmonary population. Medicare's decentralized local coverage policy process leads to policy variation, raising serious equity and quality issues. This is one of the strongest arguments for a national LMRP (Foote, Wholey, Rockwood, & Halpern, 2004).

HCFA has refused to write a standardized national pulmonary rehabilitation coverage policy due to a fear of the increase in claims it would create. There are potentially millions of dollars at stake if the coverage passes because of increased access to services. However, the government has lost sight of the potential savings it could create by keeping patients healthy and out of the hospital. The absence of a national coverage policy for pulmonary rehabilitation has the practical effect of limiting or denying access to many Medicare beneficiaries.

PROPOSED NEW LEGISLATION

The proposed plan would have some of the nuts and bolts of existing LMRPs with a few additions. The coverage would be national with no variations among the states and all states must participate. The program would be physician directed and all services ordered must meet medical necessity. Services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition. Education would be considered an integral part of any pulmonary rehabilitation program. A psychosocial evaluation would be warranted for patients that may have social adjustment disorders. Patients are expected to show measurable improvement for therapy to progress. Every program must have a medical director that has expertise in dealing with pulmonary pathophysiology, be licensed to practice in the state, and have substantial involvement in the direction of

patient outcomes (The Library of Congress, 2005).

NATIONAL EMPHYSEMA TREATMENT TRIALS

Medicare approved a study of 1000 patients who had emphysema and were treated with Lung Volume Reduction Surgery (LVRS) in the National Emphysema Treatment Trials (NETT). This surgery is designed to remove parts of the lung that are no longer participating in ventilation so that the unaffected part of the lung can operate more efficiently. Half of the participants were required to participate in a pulmonary rehabilitation program for at least 5 weeks prior to surgery and the other half were not. The study revealed that patients who participated in pulmonary rehabilitation had a much quicker recovery and were discharged sooner from the hospital than those patients who did not attend. The NETT trials have resulted in Medicare mandating that LVRS patients attend pre and post pulmonary rehabilitation before Medicare will authorize the approval of LVRS. Hospitals throughout the country are vying to be one of the locations that are eligible to perform LVRS and needless to say they will have to have a pulmonary rehabilitation in program in place before they would be considered an optimum site (Gibbons, 2006).

RELEVANT STATISTICS AND PROJECTED COSTS

The cost of national pulmonary rehabilitation coverage could be staggering. The Medicare government insurance program is already financially struggling with the introduction of part d prescription coverage. Even with conservative estimates it will cost Medicare at least 300 million just for LVRS patients to receive pulmonary rehabilitation. This number would probably only account for a small portion of patients if national coverage is passed. Keeping in mind that emphysema leading to LVRS is only one of about 20 diseases that patients could acquire in which they could benefit from receiving pulmonary rehabilitation.

GOVERNMENT PROGRAMS AND AGENCIES INVOLVED

Medicare obviously is the government agency with the most to lose if the national pulmonary coverage is passed. The public health care system is already financially vulnerable with the additional drain of prescription drug coverage it is hard to see how it could absorb another huge expenditure like national coverage for pulmonary rehabilitation. The plan is expected to go bankrupt within 20 years in its current state without any extra expenditure.

DISCUSSION

SPECIAL INTEREST GROUPS

The American Association of Respiratory Care (AARC) has lobbied for coverage clarity and would be considered by most the contributing factor if the bill is passed. The AARC would gain momentum on any future legislative issues. Their membership constituency would most likely increase as well. Some respiratory therapists are reluctant to pay the moderately priced membership fees the AARC charges; however, a political victory on a large issue such as this one may make potential members feel they would receive a good return on their investment.

The American Association of Cardiovascular and Pulmonary Rehabilitation Programs (AACVPR) is a lobbyist organization representing people that work in pulmonary and cardiac rehabilitation. This organization stands to benefit if national coverage is approved because there will be a dramatic increase in the number of pulmonary rehabilitation programs throughout the United States and most of these programs will join the AACVPR. The organization acts as an accrediting body to the cardiopulmonary rehabilitation industry and charges annual accreditation fees for member hospitals.

The American Lung Association has devoted most of its lobbying efforts towards tobacco legislation, but the organization is strongly advocating the bill. Pulmonologists stand to gain from the legislation being passed as all pulmonary rehabilitation programs must have a compensated medical director. The American Hospital Association had not advocated the bill either way. Hospitals of course have a vested interest in the bill and could be winners or losers depending on how reimbursement for the service is packaged and at what rate.

IMPLEMENTATION OF THE POLICY

The biggest issue with the policy if it is passed is the package that it would be presented under. If the coverage will pay for services but they are bundled as a one set fee per day regardless of services provided unless the fee is very high it will be a negative for all stakeholders. For example, cardiac rehabilitation programs currently operate under such fee structures allowing only a flat fee to be billed daily regardless of services rendered. This means that no services are line item billable. The average rate Medicare will pay for is 80 percent of a charge of around 106 dollars varying slightly state to state. Most cardiac rehab programs are not financially viable and hospitals frequently close them down

when looking to reduce costs. They are also reluctant to open such programs because they can add very little to the bottom line. If pulmonary is presented in the same manner it would be logical that the outcome would be the same. If the new policy will pay for unbundled services that are medically necessary by discipline and that are line item billable than all stake holders would benefit with the exception of the Medicare insurance plan, which would face even more financial strain.

Hospitals would be reluctant to start new programs if reimbursement is not feasible. Existing programs operating in states with LMRPs may at some point be unable to provide services for the same reason. Patients will not receive the same level of care from a bundled service because hospitals will try to operate programs with skeleton staff because of lower reimbursement a multidisciplinary team would not be in the budget for most programs. A major concern is that providing national coverage may actually reduce patient access to programs if the level of reimbursement is not high enough for hospitals to realize an operating profit they may focus their efforts on other outpatient services that yield better profit margins.

CONCLUSION

The pulmonary rehabilitation bill if passed could have far reaching effects on millions of pulmonary patients and potential stakeholders. LVRS and the NETT trials had made the likelihood of the bill passing much more plausible than in previous years. The coverage if offered as a bundled service plan will be highly ineffective and not serve the design for which it is intended. It could suffer the same fate as many cardiac rehabilitation programs when a fee per service day regardless of services rendered was instituted by Medicare; the programs were for the most part no longer financially viable. If services are offered line item billable based upon medical necessity the patient and financial outcomes of the programs have a much higher chance for success. Special interests groups including the AARC and AACVPR have much to gain if the bill is passed in political capital and potential operating revenues. Medicare no matter how the bill is packaged if it is passed has the daunting task of figuring out how to pay for the service while operating under an already financially strained program.

RECOMMENDATIONS

The policy should pass but not as a bundled service. This could potentially restrict access for patients because hospitals will not want to institute programs that are not

financially viable real estate inside of hospitals is a premium and administration is looking for cash cows not dogs. The federal government should earmark a higher percentage of the annual budget for Medicare especially with the addition of plan d. Pulmonary rehabilitation should be a lifetime benefit and be conditional on patient compliance, patient progression, and strict nonsmoker selection criteria. A percentage of the tobacco allotment money received by each state should be given to the pulmonary rehabilitation programs throughout the state. This would help with patient education efforts and offset program expenses to insure the longevity of the programs for continued patient access.

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