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CMS-1612-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule

The American Association for Respiratory Care (AARC) hereby presents comments on the Centers for Medicare and Medicaid Services' (CMS) proposed 2015 update to the physician fee schedule (PFS) among other items. The AARC is a national professional organization representing 50,000 respiratory therapists throughout the country. Our comments focus on proposed changes discussed in **Section II: G Chronic Care Management**.

In its 2014 physician fee schedule final rule, CMS finalized a policy to pay separately for non-face-to-face chronic care management (CCM) services effective January 1, 2015. To qualify for these services, a beneficiary must have two or more chronic conditions expected to last at least a year, or until the patient's death, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Among other things, the patient must also have access to care 24 hours a day, 7 days a week and be able to make successive routine appointments with a designated practitioner or a member of the care team. At least 20 minutes of CCM services must be provided within a 30-day period in order to qualify for payment.

In its 2015 update to the PFS, CMS is proposing to make two significant changes to the CCM services. One is to remove the requirement that, in order to count the time spent by clinical staff providing CCM services toward the minimum 20 minute rule, the clinical staff must be employed directly by the practitioner or the practitioner's practice. The other proposed change is to remove the restriction that services furnished by clinical staff under the general supervision rule, outlined by CMS in previous rulemaking, only count toward the time requirement if furnished **after** normal business hours. This change would permit CCM services furnished by clinical staff under general supervision to be counted regardless of whether the office is open or closed. CMS is also proposing to permit similar requirements for transitional care management (TCM) services which became effective January 1, 2013.

General Supervision/Lifting of Employment Restrictions

We support CMS' policy which recognizes the importance of caring for those with multiple chronic conditions and agree with the changes CMS proposes. Removing the current barriers regarding employment and general supervision in counting the time required to receive payment for CCM services provides an opportunity for practitioners, especially primary care and family practitioners, to expand their clinical staff to ensure the expertise they need to take care of patients with multiple chronic conditions is available. We believe such a change would open doors for physicians to expand their cadre of clinical staff who have the expertise to treat conditions such as diabetes, COPD and asthma.

As an example, respiratory therapists treat patients with chronic lung diseases which often present with other chronic conditions. They are the only allied health professional educated, trained and competency tested in all aspects of pulmonary medicine and the value they can bring to the physician practice setting can improve health outcomes and lower costs. According to national data from CMS' Chronic Conditions Dashboard, 51.8% of Medicare beneficiaries with Chronic Obstructive Pulmonary Disease (COPD) have five plus other conditions, while 46.82% of Medicare beneficiaries with asthma present with five or more conditions. Moreover, the Centers for Disease Prevention and Control (CDC) lists COPD as the third leading cause of death in the United States. With COPD added to the list of conditions subject to penalties under the Hospital Readmissions Reduction Program beginning October 1, 2014, it is more important than ever that physicians and their clinical staff improve the care management of their patients with multiple chronic conditions to keep them healthy and to reduce costly acute care interventions.

We believe CMS' proposed changes could assist respiratory therapists who provide vital services to patients within their scope of practice while they are in the hospital to transition to the physician office setting part-time to provide continuity of care for their pulmonary patients with multiple chronic conditions. This is especially important since management of care transitions is an integral part of the scope of CCM services and, as indicated in previous rulemaking, CMS expects "physician practices to have qualified personnel to deliver transitional care services timely in order to reduce the need for repeat emergency department visits and hospital and skilled nursing facility readmissions." Respiratory therapists are already making a difference in their hospitals by establishing best practices that reduce COPD readmissions. For example, one hospital's COPD readmission rates went from 28% to 7% when respiratory therapists utilized sound disease management practices.[1] Improving access to their expertise in the physician's practice can go further to prevent returns to the hospital.

In the past, we believe primary care and family practitioners have been reluctant to hire respiratory therapists in their practices under the "incident to" benefit because there is no

[1] Sanford Medical Center, Fargo, ND. Inpatient COPD Care Program.

guarantee that Medicare will pay the physician for the respiratory therapists' services, thus limiting their expertise in this setting. With physician shortages expected to continue and worsen over time, the need to incorporate a team of qualified, competent staff in the physician practice that includes respiratory therapists is greater than ever and the changes CMS proposes could facilitate this option. For example, an upfront investment of these experts in patient training in inhaler techniques can save time and resources by preventing uncontrolled exacerbations because of poor technique.

Comments submitted in previous CMS rulemaking recommended that "time spent by clinical staff providing chronic care management services to homebound patients in the patients' homes should count towards the time requirement if provided under general supervision." Since CMS is proposing to remove the requirement that time counts **only** if CCM services furnished under general supervision are furnished **after** normal business hours, we question whether home visits would be permitted as part of the CCM bundled payment. We would envision that nurses, respiratory therapists and even dieticians or diabetes educators who may be employed by the physician, either full-time or part-time, could assist the patient at home given the fact that the physician would not need to be in the home with the staff at the time. If permitted, home visits by respiratory therapists could bridge the gap between the patients' needs and the complex inhaler devices and new drug regimens and therapies that assist in managing their disease and keep them out of the hospital.

Given CMS' proposed revisions to CCM services furnished under general supervision rule, we recommend CMS address the issue of home visits as part of the scope of chronic care management services in its final rule.

AARC recommends CMS include self-management education and training as part of the scope of CCM services

CMS has asked for feedback regarding "any meaningful elements of the chronic care management services or beneficiary protections that may be missing…" With respect to patients with multiple chronic conditions, whether they have heart disease, diabetes, COPD or asthma, we believe a significant element that is missing as part of CCM services is self-management education and training.

In CMS' discussion of the scope of CCM services, it talks about medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications. We do not believe these services go far enough, especially since TCM services cover education to the beneficiary, family, guardian, and/or caregiver to support self-management, independent living and activities of daily living. Simply providing oversight of patient self-management of medications does not focus on the needs of pulmonary patients and the variety and complexity of devices used to treat their chronic lung disease. For those with chronic lung disease, a key to reducing costly emergency department visits and/or hospital

admissions or readmissions is to educate and train patients to recognize the symptoms and triggers of their disease to reduce or prevent the onset of acute exacerbations.

Self-management education and training is a critical element of disease management programs and we believe this element of care coordination and management of patients with multiple chronic conditions has been overlooked by CMS. To include this element as part of the scope of CCM services assumes the patient has been assessed as having the necessary skills and knowledge to self-manage his or her disease as part of the patient-centered plan of care.

Except for the self-management training benefit for diabetes patients enacted by Congress, Medicare only covers self-management when bundled with other services. Coverage of CCM services presents a perfect opportunity for CMS to expand coverage to include self-management education and training as part of the bundled payment. In addition, there are other reasons why making such a change is important.

Self-management education is included in the National Asthma Guidelines. It is also a major element of the Department of Health and Human Services' (DHHS) Strategic Framework for Multiple Chronic Conditions, as CMS notes in the proposed rule. In setting forth the goal to maximize the use of proven self-care management, DHHS states: "Even the highest quality provision of care to individuals with MCC alone will not guarantee improved health outcomes for this population." According to DHHS, self-management of one's disease is important in managing risk factors that lead to the development of additional chronic conditions. Self-management can also help to slow disease progression and improve patient outcomes, yet CMS has omitted this aspect from chronic care management.

Scientific studies also show that self-management education can reduce urgent care visits and hospitalizations, improve health status, and improve quality of life. [2,3] We believe Medicare beneficiaries with pulmonary disease working with respiratory therapists to self-manage their disease can improve their medication adherence and oxygen utilization which can minimize unnecessary, ineffective or wasteful interventions. Further, patient education and proper device selection for both inhalers and oxygen systems are critical for optimal clinical outcomes and cost effectiveness. Respiratory therapists are experts in this field and the added time they can spend with the patient to assist the physician can be invaluable. This aspect of managing patients with multiple chronic conditions is critical to improving their health outcomes and we encourage CMS to include or expand CCM coverage to include self-management education and training.

[2] Lorig, KR, et al. Chronic Disease self-management program: 2-year health status and health care utilization outcomes. *Med Care* 2001 Nov;39(11):1217-23.
[3] Effig T, et al. Self-management education for patients with chronic obstructive pulmonary disease. Cochrane Database Syst Rev. 2007 Oct 17;(4):CD002990.

Summary

The AARC strongly supports CMS' proposed changes 1) to permit CCM services furnished by clinical staff under general supervision rules to count toward the minimum time required in order to bill Medicare for the services regardless of whether they are furnished during normal business hours or when the office is closed, and 2) to no longer require clinical staff to be employed directly by the physician or physician practice in order to furnish CCM services under general supervision. We also agree with the proposal to make similar changes to TCM services in order to make them equivalent. If CMS finalizes these provisions, we recommend CMS address in the final rule whether home visits would be included as part of CCM services.

We believe relaxing these rules offers incentives and flexibility for primary care and family practitioners to supplement their cadre of clinical staff who have the expertise to treat conditions such as diabetes, COPD and asthma. For example, adding the expertise of respiratory therapists who are trained and educated in all aspects of pulmonary care to the physician office setting to treat pulmonary patients with multiple chronic conditions can assist in managing their disease and help to improve medication adherence and oxygen utilization which can reduce unnecessary emergency room visits and hospital readmissions.

AARC recommends CMS include self-management education and training as part of the CCM services, consistent with TCM services that include patient education. We do not believe simple medication reconciliation and oversight of patient self-management of medications goes far enough in managing patients with multiple chronic conditions, especially those with chronic lung disease. Self-management is an integral part of the DHHS Strategic Framework for Multiple Chronic Conditions and studies show that it can reduce urgent care visits and hospitalizations and improve health status and quality of life. For example, pulmonary patients working with respiratory therapists through self-management education can learn 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.

We appreciate the opportunity to comment on the proposed update to the 2015 physician fee schedule and encourage CMS to consider expanding CCM services to include self-management education and training.

Sincerely,

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President