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***Submitted via e-mail to: [www.chronic\\_care@finance.senate.gov](mailto:www.chronic_care@finance.senate.gov)***

January 26, 2016

The Honorable Orrin Hatch  
Chairman, Senate Finance Committee  
104 Hart Senate Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member, Senate Finance Committee  
221 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Johnny Isakson  
United States Senate  
131 Russell Senate Office Building  
Washington, DC 20510

The Honorable Mark Warner  
United States Senate  
475 Russell Senate Office Building  
Washington, DC 20510

Dear Senators Hatch, Wyden, Isakson and Warner:

The American Association for Respiratory Care (AARC) applauds the Senate Finance Committee's December 2015 release of its Policy Options Document developed by the Committee's Bipartisan Chronic Care Working Group (Working Group) and its efforts on behalf of those who suffer from chronic conditions. The AARC is a national professional organization with a membership of 50,000 respiratory therapists (RTs) and whose organizational activities impact over 170,000 practicing respiratory therapists across the country. These health care professionals are trained, educated and competency tested to treat high-risk patients with chronic respiratory conditions such as asthma and chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis in all care settings.

The report emphasizes the themes that emerged based on public input and follow-up meetings with various stakeholders which include developing and implementing policies designed to improve disease management, streamline care coordination, improve quality and reduce Medicare costs. Based on the comments that follow, we believe that recognition of respiratory therapists and the care they can provide to patients with chronic respiratory conditions in the home and via telehealth services and remote patient monitoring can accomplish all of these goals. Our comments focus specifically on quality care in the home setting and expanding telehealth and remote patient monitoring services.

## Receiving High Quality Care in the Home

### Expanding the Independence at Home Model of Care

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The Independence at Home (IAH) demonstration is designed to deliver timely, in-home primary care to Medicare beneficiaries with multiple chronic conditions and functional impairments. To participate, the entity must be comprised of physicians or nurse practitioners and include a team that may include physician assistants, clinical staff and other health and social service staff who have experience providing home-based primary care. The demonstration project was mandated by Congress and is expected to end in 2017. The Working Group is considering not only “expanding the demonstration into a permanent, national program” but is also “contemplating additional modifications to the program.”

As part of the current demonstration, in order for a Medicare beneficiary to be eligible to participate, they must:

- Be entitled to Medicare benefits under Part A and be enrolled in benefits under Part B;
- Not be enrolled in a Medicare Advantage (MA) plan under Part C;
- Not be enrolled in a Program for All-Inclusive Care for the Elderly (PACE) program under SSA Title 18 Sec 1894;
- Have two or more chronic conditions;
- Have had a hospital admission within the past 12 months;
- Have received acute or sub-acute rehabilitation services within the past 12 months (including skilled nursing facility, home health, and inpatient and outpatient rehabilitation services); and
- Require assistance of another person (assistance may include supervision, cueing, or hands-on help) for two or more activities of daily living (ADL).

The delivery of health care today is vastly different than when the Medicare law was first enacted. Over the years there has been much progress in changing the landscape from one which initially focused on inpatient and institutional care to services in a variety of outpatient settings.

What has not changed, however, is the ability of the Medicare program to recognize that the provision of pulmonary medicine has also changed with the times, and that respiratory therapists and the services they provide in the outpatient setting, especially in the home, are vital to keeping patients who suffer from respiratory diseases such as COPD, asthma, pulmonary hypertension, pulmonary fibrosis and cystic fibrosis healthy and out of the hospital.

Part of the problem is the mindset of the health care system that respiratory therapists belong primarily in the acute, hospital inpatient setting. The Medicare program, for example, does not recognize respiratory services in the statute, except in the case of services furnished in a Comprehensive Outpatient Rehabilitation Facility. Moreover, unlike numerous other health care professionals who are recognized in section 1861(s)(2) of the Social Security Act,

respiratory therapists are notably missing, thus creating a barrier to access for many Medicare beneficiaries who rely on their expertise, especially as it relates to post-acute care.

Access in the home to these highly trained, educated and competency tested health care professionals is compromised further due to the creation of the competitive bidding program. Home medical equipment suppliers today have to make difficult choices as to whether it is economical for them to hire a respiratory therapist if they have flexibility under to do so under state law. This is due to the fact that the durable medical equipment (DME) benefit, which the Centers for Medicaid and Medicare Services (CMS) considers an “equipment” benefit only, does not pay for the professional services of a respiratory therapist even though their expertise is critical, especially when it comes down to determining the most appropriate respiratory equipment based on the patient’s individual health care needs.

**Recommendation: The IAH demonstration should be expanded to include a patient’s need for respiratory services**

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The Working Group is considering modifications to the IAH demonstration and asked for comments on specific modifications that could be made to encourage additional primary care practices to participate beyond those currently in the program. While we agree that the current criteria for admission in the IAH demonstration are vital requirements for in-home care, what is missing from the criteria is a patient’s need for respiratory services that include the use of complex respiratory equipment.

Examples of respiratory equipment include oxygen systems and portable oxygen concentrators, inhaled medical devices such as nebulizers, home mechanical ventilation that can have multiple functions, certain bi-level respiratory assist devices that provide continuous or intermittent positive pressure flow with or without a backup rate, continuous airway positive pressure devices used to treat obstructive sleep apnea, and aerosol delivery systems used to administer inhaled medications. Unlike other items of durable medical equipment (DME), patients with chronic respiratory conditions rely on this type of complex equipment which, if it fails, could mean the difference between life and death. This is particularly true for those patients who receive support for home mechanical ventilation.

Since the IAH demonstration combines elements of care that are currently provided as part of other Medicare benefit categories such as home health services, including physical and occupational therapy, speech-language pathology and audiology services, it would appear that including respiratory services furnished by respiratory therapists as part of the care provided under the IAH demonstration is reasonable.

**Recommendation: The IAH demonstration model and criteria should be designed in a way to make it easier to provide access to respiratory therapists for patients needing their expertise in the home setting**

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As noted above, to participate in the IAH demonstration the entity must be comprised of physicians or nurse practitioners and include a team of physician assistants, clinical staff and other health and social service staff who have experience providing home-based primary care.

Because CMS' website does not provide specific information about the providers participating currently in the IAH demonstration, it is not possible to glean information from the applications as to the type of clinical staff they have on board.

Currently, the only provision that permits Medicare to pay for the services of respiratory therapists who work in a physician's office is under the benefit category known as the "incident to" provision. "Incident to" services are those that are:

- Furnished in a physician's office or clinic;
- Commonly rendered without charge or included in the physician's bill;
- Integral, though incidental, to the physician's services in the course of diagnosis or treatment of an injury or illness; and,
- Furnished under the direct supervision of the physician

From our experience, primary care physicians are generally reluctant to hire respiratory therapists in their offices for a variety of reasons. These can include 1) lack of volume of pulmonary patients due to referrals to pulmonary specialists, 2) inability to cover benefit costs that may be afforded to respiratory therapists in the inpatient hospital setting, and 3) uncertainty with respect to Medicare reimbursement for the respiratory therapist's services. Expanding the IAH demonstration to include beneficiaries who need respiratory services can open the door to increased access to these experts.

Recently, CMS proposed revisions to the discharge planning process with an emphasis on discharge to home and the need for patients' goals and preferences to be accounted for as part of the discharge planning process. The proposed revisions are meant to strengthen the process to avoid delays in the transition from hospital to home and to other post-acute care providers such as skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities and home health agencies.

A qualified respiratory therapist needs to be part of the IAH demonstration interdisciplinary team to ensure appropriate post-acute care needs are available and met subsequent to discharge for those beneficiaries who suffer from chronic respiratory conditions. For example, it makes no sense to have a hospital respiratory therapist as the most qualified individual to administer respiratory care and to assess the needs of patients with chronic respiratory conditions prior to discharge and have no recognized respiratory therapists to provide a continuum of care post-discharge in the home when they are credentialed and licensed to do so.

We do not dispute that nurses are vital to home care and are qualified to perform many services. However, when it comes to complex medical equipment and treating patients with chronic respiratory conditions, respiratory therapists are the experts in home care. Respiratory disease managers, for example, are qualified to furnish a variety of services designed to educate patients on the triggers and symptoms of their disease in order to prevent an acute exacerbation that may result in more expensive inpatient acute care or hospital readmissions.

A comprehensive disease management program furnished by qualified respiratory therapists includes the following services:

- Patient education on self-management of their disease;
- Training and education in use of prescribed self-monitoring devices such as peak flow measurement and pulse oximetry;
- Direct observation and assessment of the patient's ability to self-administer aerosol medications;
- Training and education on the proper inhaler technique for use of aerosol medications with nebulizers, metered-dose inhalers, and dry-powdered inhalers;
- Collaboration with the physician or other qualified practitioner on the appropriate selection of aerosol medications;
- Smoking cessation counseling;
- Collaboration with the physician or other qualified practitioner on the appropriate diagnostic testing to identify potential necessity for appropriate respiratory DME (e.g., home oxygen, including portable oxygen concentrators, continuous positive airway pressure (CPAP) for sleep apnea, and ventilator support)
- Education and training on the appropriate use of respiratory equipment in order to safely self-manage care following discharge as ordered by the physician or prescribing qualified practitioner;
- Education and training in compliance with medications and devices incorporated into discharge plans, including self-management plans
- Developing an action plan that enables patients to recognize the appropriate response to self-managing their chronic disease according to their symptoms and results of prescribed self-monitoring; and,
- Monitoring the disease management treatment plan to ensure patient compliance.

**Recommendation: The IAH Demonstration should consider using the hierarchical condition categories (HCC) risk-adjustment model to identify complex chronic care beneficiaries for inclusion in the IAH demonstration rather than relying on a hospital stay within 12 months of participation in the program.**

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As we understand it, the HCC model is currently used in the Medicare Advantage program to more accurately predict the cost of furnishing care to enrollees and to properly fund the plans for their expenses. The Working Group is considering whether to use the HCC model as part of the IAH demonstration to identify complex chronic care beneficiaries. While this issue is not within our area of expertise, we have read several studies that discuss the advantages and disadvantages of this type of risk adjustment used to gauge how to appropriately pay for those beneficiaries who are sicker and represent a higher cost of care to the Medicare program.

Beneficiaries who have multiple chronic conditions that include chronic respiratory conditions are some of the most costly to the health care system. For example, COPD was ranked by the

Medicare Payment Advisory Commission (MedPAC)<sup>1</sup> as the 4<sup>th</sup> most costly condition in terms of hospital readmissions, resulting in CMS adding it to the list of conditions subject to hospital readmission penalties.

In reviewing reports that address the HCC risk model, the predictive ratios of the cost of treating COPD are included. One report prepared for CMS by RTI International<sup>2</sup> showed predictive ratios for selected groups of HCCs that together comprise a single serious chronic condition that is common in the Medicare population in addition to predictive ratios for beneficiaries with combinations of two or three of the HCC groups, for example, diabetes, cancer and COPD. The results indicated that the CMS-HCC model accurately predicts expenditures for beneficiaries who have combinations of major chronic illnesses common in the Medicare population.

The 2014 CMS Dashboard on Chronic Conditions<sup>3</sup> reports 52.27% of Medicare beneficiaries with COPD have 5 or more chronic conditions. In a 2012 MedPAC report<sup>4</sup> that addressed risk adjustment issues in the Medicare Advantage program, adding the number of conditions to the CMS-HCC model that included COPD was shown to improve predictive accuracy for beneficiaries who have many conditions. The report estimated several versions of the CMS-HCC risk-adjustment model using a regression based on a 5 percent sample of fee-for-service (FFS) beneficiaries. Since the Working Group asks whether HCC risk scores are available for FFS beneficiaries, we point out that the MedPAC report addresses whether CMS should use FFS or Medicare Advantage data to estimate the CMS-HCC model.

If the Working Group were to accept the AARC's recommendation to add beneficiaries who need respiratory care to the criteria for admission in the IAH demonstration, it would be worthwhile to consider the evaluation of DME as a risk adjuster as part of the HCC risk adjustment model. A 2000 report<sup>5</sup> compiled by Health Economics Research, Inc., evaluated integrating DME and procedures into diagnostic classifications. At the time, the analysis resulted in new HCCs grouped into "two hierarchies" of which "respiratory therapy" was one. This category included oxygen, bi-level respiratory assist devices that provide continuous or intermittent positive pressure and nebulizers used to administer inhaled medications. Overall, one conclusion of the evaluation was that "adding DME as a risk adjuster does significantly improve predictive accuracy, especially those utilizing Medicare DME and home health

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1 Medicare Payment Advisory Commission: Report to the Congress "Promoting Greater Efficiency in Medicare." June 2007. Chapter 5: Payment policy for inpatient readmissions. Table 5-3, page 116.

2 Pope, GC, et al. Evaluation of the CMS-HCC Risk Adjustment Model, RTI International. March 2011. Prepared for the Centers for Medicare and Medicaid Services. Contract No HHSM-500-2005-00291 TO 0006.

3 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CCDashboard.html>

4 Medicare and the Health Care Delivery System: Report to the Congress. June 2012. Medicare Payment Advisory Commission. Chapter 4: issues for risk adjustment in Medicare Advantage; pp. 95-110.

5 Pope, GC, et al. Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment – Final Report. Health Economics Research, Inc. Prepared for the Health Care Financing Administration: December 21, 2000. Contract No. 500-94-048.

services...” Further, it was noted that beneficiaries with certain diagnoses, one of which is COPD, “are clearly the heaviest users of DME...”

Since the Working Group is soliciting feedback on changes that could improve the IAH program design while still achieving savings, for the above reasons, we believe the IAH demonstration should be modified to include beneficiaries who need respiratory services as a criterion for participation

<b>Improving Access to Telehealth and Remote Patient Monitoring Services</b>
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**Telehealth in Medicare Advantage (MA) plans and Accountable Care Organizations**

The Working Group is considering permitting Medicare Advantage plans to include certain telehealth services in its annual bid amount. In addition, the Working Group is considering modifying the requirements for telehealth services provided by ACOs in the Medicare Shared Savings Program. In either case, while there is limited flexibility in both programs to include some telehealth and other technology services, there is no separate Medicare payment associated with the services. Moreover, Section 1834(m) of the Social Security Act adds further restrictions on telehealth payments.

The Working Group is seeking input on whether telehealth services provided by MA plans should be limited to those allowed under traditional Medicare or whether additional telehealth services should be permitted. With respect to ACOs, the Working Group wants input on whether the current originating site requirements should be lifted and additional originating sites added. The Working Group is also expected to clarify that ACOs in the Medicare Shared Savings Program may furnish remote patient monitoring services for which separate payment is not made under FFS Medicare.

**Recommendation: The Working Group should consider specific waivers to current Medicare law to ensure that the inclusion of expanded access by Medicare beneficiaries to telehealth and remote patient monitoring (RPM) services are available not only in the in MA and ACO plans, but in other alternate payment models (APM) as well.**

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In previous comments to the Working Group last June, the AARC noted its strong support for HR 2948, the Medicare Telehealth Parity Act, a bipartisan bill introduced by Representatives Thompson, Harper, Black and Welch in July last year. Although there are several bills in Congress that propose some form of coverage and payment for telehealth and RPM services, HR 2948 is the only bill to add practitioners that are not currently recognized in the Medicare statute under §1834(m)(4)(E) to perform such services.

Among the provisions, the bill covers 1) respiratory therapists as qualified telehealth professionals in addition to physical and occupational therapists, speech-language pathologists and audiologists, and certified diabetes educators; 2) respiratory services, physical therapy, plus other therapies as covered telehealth services; 3) an individual’s home as a telehealth site in conjunction with home health services that include hospice care, home dialysis and durable medical equipment; and, 4) remote patient monitoring services for chronic conditions including COPD, heart failure and diabetes.

Currently, the only practitioners recognized by Medicare to provide telehealth services are physicians, nurse practitioners, physician assistants, certified nurse specialists, nurse-midwives, clinical psychologists, clinical social workers and registered dietitians or nutrition professionals. It is important to include respiratory therapists as telehealth professionals because respiratory disease managers can, through a comprehensive telehealth disease management program discussed earlier, reduce exacerbations and lower the incidence of costly acute care interventions as well as improve medication adherence and oxygen utilization for those Medicare beneficiaries who suffer from chronic respiratory conditions. Adding an individual's home as a telehealth site also increases access to respiratory therapists by Medicare beneficiaries who are not able to benefit from their services under current law.

**Recommendation: To ensure that current law does not impede the inclusion of expanded access by Medicare beneficiaries to telehealth services, we strongly support a waiver for MAs and alternative payment models (APM), including ACOs, of the following specific Medicare restrictions in section 1834(m).**

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- The last sentence of section 1834(m)(1) to permit an APM or MA plan to provide and bill for health services provided by store-and-forward means (such as transmission of medical images) to beneficiaries who live outside of an Alaska or Hawaii demonstration site as of December 31, 2000.
- Section 1834(m)(4)(C)(i)(II) to permit an APM or MA plan to provide health services by video conferencing for Medicare beneficiaries who live in metropolitan counties.
- Section 1834(m)(4)(C)(ii) to permit an APM or MA plan to provide for telehealth services originating from a beneficiary's home, a hospice and anywhere else from which a beneficiary seeks service (without regard to an originating site fee).
- **Section 1834(m)(4)(E) to permit a beneficiary in an APM or MA plan to get otherwise covered Medicare services when furnished by respiratory therapists, physical therapists, occupational therapists, speech-language pathologists, audiologists and other health professionals via telehealth.**
- Section 1834(m)(4)(F)(i) to permit an APM to provide additional CPT and HCPCS codes for Medicare covered services provided via telehealth.

If MA plans and ACOs receive waivers from these five specific Medicare restrictions, particularly originating site and geographic restrictions, they can take the lead in demonstrating the value of telehealth remote patient monitoring and other technologies in innovating care delivery and improving access and efficient delivery of care in both rural and urban settings.

### Summary

The AARC commends the extensive amount of work undertaken to date by the Senate Finance Committee's Bipartisan Chronic Care Working Group in its initiative to improve care for the millions of Americans managing chronic illnesses. We support the goals outlined in the report that strive to:



- Increase care coordination among individual providers across care settings who are treating individuals living with chronic diseases;
- Streamline Medicare’s current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases; and
- Facilitate the delivery of high quality care, improve care transitions, produce stronger patient outcomes, increase program efficiency, and contribute to an overall effort that will reduce growth in Medicare spending.

Recognition of respiratory therapists and the role they can play in achieving the goals of the Working Group for those Medicare beneficiaries with chronic respiratory conditions is long overdue. The Medicare program limits access to these health care experts in the home setting. Any legislative initiative developed by the Working Group to address this shortage would not only help to reduce hospital readmissions, improve outcomes and lower costs, but will give Medicare the opportunity to collect data that demonstrate the value respiratory therapists bring to the health care delivery system overall. Further, any expansion of telehealth services and remote patient monitoring should permit respiratory therapists as disease managers to furnish a chronic disease management program via telehealth to beneficiaries in their home or through current or expanded originating sites.

We appreciate the opportunity to provide comments on the Policy Options Document. If you have further questions please contact Anne Marie Hummel, AARC’s Regulatory Director at [anneh@aacrc.org](mailto:anneh@aacrc.org) or 703-492-9764, or Kim Turner, AARC’s Legislative Director at [kim.turner@aacrc.org](mailto:kim.turner@aacrc.org) or 202-557-1205.

Sincerely,



Frank R. Salvatore, RRT, MBA, FAARC  
President