AMERICAN ASSOCIATION FOR RESPIRATORY CARE
9425 North MacArthur Blvd., Suite 100, Irving, TX 75063, (972) 243-2272, Fax (972) 484-2720
http://www.aarc.org, E-mail: info@aarc.org

July 20, 2015

Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Reference: CMS-2390-P
Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Mr. Slavitt:

On behalf of the American Association for Respiratory Care, I am writing in response to the request for comments on proposed revisions to update the Medicaid and Children's Health Insurance Programs' (CHIP) managed care regulations and strengthen the delivery of quality care for beneficiaries. The AARC is a national professional organization representing over 50,000 respiratory therapists who treat patients with chronic lung disease in all care settings and whose organizational activities impact approximately 175,000 practicing respiratory therapists across the country.

Among the many changes proposed, the rule would revise *§438.208 Coordination and continuity of care* to ensure "each enrollee receives access to an ongoing source of care appropriate to their needs." With respect to CHIP, *§457.760 CHIP Component of the State comprehensive quality strategy* requires each state to "address how it will assess and improve the quality of health care and services furnished to all CHIP enrollees."

For patients suffering from debilitating chronic lung disease including pediatric asthma patients, we believe it is imperative that Medicaid managed care plans have a sufficient number of licensed respiratory therapists on staff in order to meet the goals of the proposed regulations. Respiratory therapists are the only allied health professionals educated, trained, and competency tested in all aspects of pulmonary medicine.

A study published in 2014 on *State-Based Medicaid Costs for Pediatric Asthma Emergency Department (ED) Visits*[1] concluded there were "approximately 629,000 ED visits for pediatric

asthma for Medicaid/CHIP enrollees, costing $272 million in 2010." According to the study, prevalence and costs vary widely among states, but seven states (California, Florida, Georgia, Illinois, New York, Pennsylvania and Texas) were estimated to have spent more than $10 million each in 2010 on asthma-related visits for this population.

Beginning in 2014, rule changes permitted State flexibility to pay for asthma interventions using nontraditional providers such as certified asthma educators in a nonclinical setting as long as certain conditions were met. Although licensed respiratory therapists are trained and educated to treat asthma patients, some seek to add the Certified Asthma Educator credential to their resume. Currently there are 3,449 credentialed asthma educators of which 43% or 1,489 are respiratory therapists whose expertise can go a long way to benefiting both adults and children being treated for asthma in Medicaid managed care plans. Over 4,500 professionals have been assisted by AARC's Asthma Educator Certification Preparation course which prepares applicants for the examination conducted by the National Asthma Education Certification Board. The AARC also partnered with the US Department of Health and Human Services, National Institutes of Health, the National Heart, Lung and Blood Institute, and the National Asthma Education and Prevention Program in developing a resource document titled "Making a Difference in the Management of Asthma: A Guide for Respiratory Therapists."[2]

Caring for Medicaid pulmonary patients suffering from Chronic Obstructive Pulmonary Disease (COPD) can be costly. A study on the *Clinical and Economic Burden of COPD in a Medicaid Population*[3] concluded that COPD patients were "more than twice as likely to have a hospitalization or home healthcare visit/durable medical equipment compared to non-COPD patients", leading to Medicaid incremental costs and medical resources. According to the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project (HCUP),[3] a 25% 30-day hospital readmission rate for Medicaid recipients is the highest among all insurance groups.

One of the underlying causes for hospital readmissions and ED visits is acute exacerbations. Self-management education and training taught by respiratory therapists helps patients to recognize and reduce the symptoms and triggers of their chronic lung disease which can lead to reduced exacerbations and lower acute care costs. Patients who properly self-manage their chronic lung disease working with respiratory therapists can also slow their disease progression and improve their health status.

The AARC is in the process of proposing to collaborate and partner with State Respiratory Care Societies and State Medicaid programs to change the paradigm of Medicaid readmission rates by developing and testing innovative delivery models that will increase access to the services and skill set of respiratory therapists. The overarching objectives of this proposal focus on improving the quality of care and patient outcomes, expanding access to treatment and respiratory care services, and reducing the cost of care to the patient and the State Medicaid Program. The approach is centered on concerted efforts to develop efficient delivery models

aligning the services and expertise of the licensed respiratory therapist with the care and treatment of the Medicaid COPD recipient. Examples of the proposed pilot projects include the following:

- Placing respiratory therapists in targeted physician practices that have a high percentage of Medicaid COPD patients.
- Designating and supporting specific community-based, respiratory outreach programs developed within a hospital respiratory services department that could be directed specifically to manage Medicaid COPD patients' post-hospital discharge care and case management.
- Exploring development of a pilot program involving hospitals and hospital-owned physician practices that provide services to a large volume of COPD Medicaid patients.
- Increasing access to respiratory services for Medicaid COPD patients in physician practices that do not currently accept Medicaid patients through employment or contractual arrangements with licensed respiratory therapists.

Another area that could result in improved quality care and access to meet the needs of the pulmonary patient working with respiratory therapists is in the area of medication management and adherence. Medication non-adherence has been estimated to cost the U.S. health care system between $100 billion and $289 billion in direct costs.[4] In order to gain optimal clinical outcomes and improve cost effectiveness, patient education and proper device selection for both inhalers and oxygen systems are critical. Licensed respiratory therapists are experts in this field and the added time they can spend with the patient to assist physicians in the managed care setting can be invaluable.

Other services provided by skilled respiratory therapists include oxygen titration and selection of appropriate oxygen devices, follow-up for medication management, monitoring of compliance with the physician's care plan, and earlier detection of exacerbations before the patient deteriorates to warrant an emergency department visit or hospital admission or readmission. Studies have shown that respiratory therapists' expertise is valuable in reducing hospital and ED visits and lowering costs while improving patient outcomes.

- A one-year randomized controlled trial at five VA medical centers led by a respiratory therapist case manager implementing a simple disease management program reduced COPD-related hospitalizations and emergency department visits by 41%.[5]
- An evaluation of an oxygen therapy clinic managed by respiratory therapists suggests that home oxygen patients can significantly decrease inappropriate supplemental oxygen use which can result in significant cost savings while improving health-care delivery.[6]

Recently the AARC, in partnership with the Allergy and Asthma Network, COPD Foundation, American Association of Cardiovascular and Pulmonary Rehabilitation, Pulmonary Fibrosis

Foundation, and Cystic Fibrosis Foundation developed a Pulmonary Disease Educator program to provide pulmonary disease management information health care providers need to improve long-term pulmonary disease care and improve patient quality of life. It focuses on the key components of pulmonary disease education for COPD, pulmonary fibrosis, asthma, pulmonary hypertension, and cystic fibrosis. The course also provides instruction on pulmonary function technology, tobacco cessation, pulmonary rehabilitation, patient education, and many other vital areas of effective pulmonary disease management – all of which can lead to improved outcomes for Medicaid/CHIP enrollees with chronic lung disease when furnished by respiratory therapists.

Summary

Respiratory therapists can make a difference in the lives of pulmonary patients, including children who suffer the debilitating consequences of asthma. Medicaid managed care plans and their patients can reap the benefits of employing and utilizing the expertise of respiratory therapists -- hospital admissions, readmissions and ED visits can be reduced, acute exacerbations can be prevented, adherence through proper demonstration and training on use of respiratory devices including oxygen can be improved, and the progression of pulmonary disease can be slowed with self-management education and training.

To improve the overall efficiency of Medicaid managed care plans, promote care coordination and quality of care, and to strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries as outlined in the subject proposed rule, we encourage States to include respiratory therapists as part of the team.

Sincerely,

Frank R. Salvatore, RRT, MBA, FAARC
President

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[1] Pearson WS, Goates SA, Harrykissoon SD, Miller SA. State-Based Medicaid Costs for Pediatric Asthma Emergency Department Visits. *Prev Chronic Dis* 2014;11:140129.DOI:http://dx.doi.org/10.5888/pcd11.10139. Accessed July 10, 2015.

[2] Making a Difference in the Management of Asthma: A Guide for Respiratory Therapists. NIH Publication No. 02-1964. May 2003.

[3] D'Souza AO, Shah M, Dhamane, AD, et al. Clinical and Economic Burden of COPD in a Medicaid Population. *COPD: Journal of Chronic Obstructive Pulmonary Disease*. April 2014, Vol.11,No.2:212-220. (doi: 10.3109/15412555.2013.836168). http://informahealthcare.com/doi/abs/10.3109/15412555.2013.836168?journalCode=cop. Accessed July 20, 2015.

[4] Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment Number 208. 4. Medication Adherence Interventions: Comparative Effectiveness. Closing the Quality Gap: Revisiting the State of the Science. Executive Summary.

[5] Aishwarya P, et al. Critical Comparisons of the Clinical Performance of Oxygen-conserving Devices. *Am J Respir Crit Care Med* Vol 181.pp1061-1071, 2010. DOI: 10.1164/rccm.200910-1638OC, February 4, 2010.

[6] Chaney, JC, et al. Implementation of an Oxygen Therapy Clinic to Manage Users of Long-term Oxygen Therapy. *Chest* 2002;122:1661-1667)