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

October 7, 2016

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

RE: CMS-4168-P: Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE)

Dear Mr. Slavitt:

As President of the American Association for Respiratory Care (AARC), I am responding to the request for public comments on the subject proposed rule that would revise and update the requirements for the Programs of All-Inclusive Care for the Elderly (PACE) under the Medicare and Medicaid programs. The AARC is a national professional organization with a membership of 50,000 respiratory therapists who treat patients with chronic respiratory diseases such as asthma and Chronic Obstructive Pulmonary Disease (COPD) and whose organizational activities impact over 170,000 practicing respiratory therapists across the country.

PACE provides care to the frail and elderly through a managed care service delivery model to dually eligible Medicare/Medicaid enrollees who have been assessed as eligible for nursing home care placement within their respective state. This proposed rule would make several significant changes to the personnel qualifications of those individuals involved with direct participant contact as well as the composition and responsibilities of the Interdisciplinary Team (IDT). Our comments focus on these provisions specifically.

Personnel Qualifications

Under current regulations, personnel qualifications for staff with direct participant contact require the individual to have a minimum of 1 year of experience with a frail or elderly population. Recognizing that PACE Organizations (PO), especially those in rural areas, might have candidates who meet all other qualifications except the 1 year experience with the frail or elderly, CMS is proposing to provide flexibility by allowing the PO to hire such personnel as long as the individual receives required training that meets industry standards upon employment.

The AARC supports the proposal to allow POs flexibility in hiring individuals who meet all personnel qualifications except the requirement to have 1 year of experience with the frail or elderly population because we believe it opens the door for the PO to hire respiratory therapists to serve their patient population.

The practice of respiratory care encompasses activities in diagnostic evaluation, therapy, disease management and education of the patient, family and public. These activities encompass but are not limited to: 1) performing tests and studies of the cardiopulmonary system; 2) application and monitoring of medical gases and environmental control systems; 3) bronchopulmonary hygiene; 4) pharmacological agents; 5) hemodynamic cardiovascular support; and 6) promoting knowledge and management of the patient's disease process, medical therapy and self-help through education.

Many of the patients treated by respiratory therapists are frail and elderly as chronic lung disease has a debilitating effect on the patient's quality of life. Therefore, we believe they are eminently qualified to serve the PACE population. However, there may be instances, especially in rural areas, where the respiratory therapist has not served fully the 1 year requirement. In those cases, we believe training upon hiring to sensitize him or her to the complexities and differences in geriatric patients would be in order.

Interdisciplinary Team (IDT)

Currently, the IDT must be comprised of a minimum of eleven (11) specific disciplines (e.g., Master's level social worker, physical therapist, occupational therapist, home care coordinator, dietitian, etc.) As part of a participant's initial assessment, eight of the eleven members are specifically required to evaluate the participant in person at appropriate intervals and develop a discipline-specific assessment of the participant's health and social status.

CMS is proposing a number of revisions to current regulations regarding the IDT, all of which are designed to give the PO additional flexibility in determining how best to serve its participants' needs and to ensure that professionals may be included in the initial comprehensive assessment as opposed to a reassessment. Two alternatives are being proposed. The first alternative would be to eliminate altogether the composition requirements in current regulations. The second alternative is to delete the requirement that members of the IDT must serve primarily PACE participants which would allow flexibility of the PO to determine their staffing needs without requesting a waiver.

The AARC supports CMS' proposed alternative to delete the requirements in §460.102(b) related to the composition of the IDT. With additional flexibility of the PO to determine the composition of the team, we recommend POs hire respiratory therapists as a member of the IDT to serve those participants that suffer from chronic pulmonary disease. We believe this is a specialty that heretofore has been missing from the team composition and is vital to addressing needs of the elderly and frail population who have COPD, asthma, sleep apnea and other respiratory ailments.

At a minimum, a PO must provide the following services:

- Primary care, including physician and nursing services
- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

This does not preclude the PO from adding much needed respiratory therapy to the cadre of services it provides and we recommend its inclusion in order to ensure accessible and adequate services to meet the needs of its participants.

For example, care management is a critical requirement of the PO that cannot be waived. As such, there are a number of activities we recommend for treating PACE participants with chronic pulmonary disease for which respiratory therapists with their expertise in pulmonary medicine would be an asset to the PO. These include:

- 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 on the appropriate selection of aerosol medications based on the patient's diagnosis.
- Smoking cessation counseling.
- With respect to chronic respiratory patients on long-term oxygen therapy, education and training on the appropriate dose of oxygen depending on the activity of the patient in order to self-manage the drug.
- Developing an action plan that enables patients to recognize the appropriate response to self-managing their chronic disease according to their symptoms and assists them in taking more responsibility for their health and outcomes.
- Monitoring the disease management treatment plan to ensure patient compliance.
- Ensuring medication reconciliation and adherence.

PACE covers all Medicare and Medicaid medically necessary care and services as well as those not covered by these programs. Overall, a PO provides its participants with "comprehensive integrated acute and long-term care services." The advantage of PACE is there are no limitations or conditions as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid. The benefit package covers care across a continuum of health care settings that permits participants to continue to live at home rather than be institutionalized.

With respiratory therapists as part of the IDT, innovative respiratory care protocols can shift the traditional home care practice from just assessing vital signs to promoting improved quality of life. As an IDT member, respiratory therapists would have the opportunity to improve

functional performance of PACE participants who suffer from chronic pulmonary disease by focusing on greater activity capability, dyspnea and anxiety lowering skills; shifting from short-term drug therapy to long-term exacerbation control; and, engaging the participant in managing his or her symptoms. To that end, instead of solely relying on vitals, respiratory therapists can build ambulatory capability, measure oxygen titration during activity, employ medication best practice standards, teach self-management skills, and incorporate advanced dyspnea measures such as the COPD Assessment Tool.

According to CMS' Chronic Conditions Dashboard, 52% of Medicare beneficiaries who suffer from COPD and 47% of those suffering from asthma have five or more other conditions. As more focus is placed on reducing hospital readmissions, respiratory therapists are increasingly working as members of multidisciplinary teams throughout the health care spectrum to provide pulmonary disease and care management services designed to keep patients from costly acute care interventions. That is why it is particularly important for the PO to include respiratory therapists on the IDT in order to maximize their expertise in the home since PACE participants who would otherwise qualify for nursing home care have complex unmet needs and often rely on complex respiratory equipment to survive, including noninvasive mechanical ventilation.

In recognition of the ever evolving health paradigm and changes in the delivery of non-institutional care, today's respiratory care field requires a more highly educated professional than ever before. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of patients with multiple chronic diseases clearly mandate respiratory therapists achieve formal academic preparation commensurate with an advanced practice role.

Professional respiratory therapists must be capable of supporting their patients through the maze of medical services and resources which are now available to them, educating patients regarding pathophysiology, diagnostic, treatment regimens and positive self-care for better outcomes and wellness. That is why we believe the time has come to include respiratory therapists as part of the IDT to serve PACE participants' complex chronic pulmonary disease needs.

We appreciate the opportunity to comment on the proposed rule and strongly support CMS' decision to update long-standing PACE provisions that recognize the ever changing health care delivery system in caring for the frail and elderly.

Sincerely,

Frank R. Salvatore, RRT, MBA, FAARC
President