AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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June 22, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1679-P: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, etc.

Dear Ms. Verma:

As President of the American Association for Respiratory Care (AARC), I am pleased to offer comments on the subject proposed FY 2018 payment update for skilled nursing facilities (SNF) among other things. The AARC is a national professional organization representing over 47,000 respiratory therapists who treat patients with chronic respiratory diseases and whose expertise and skills include a full array of respiratory therapy services in the SNF setting that includes oxygen therapy, inhalation medication management and ventilator management.

When Congress passed the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act), one of the key provisions was to standardize patient assessment data among post-acute care facilities, i.e., Skilled Nursing Facilities (SNFs), Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), and Home Health Agencies (HHAs), in order to enable data exchange among these providers to facilitate coordinated care and improved Medicare beneficiary outcomes. The standardized assessment data includes five categories: 1) functional status; 2) cognitive function; 3) special services, treatment and interventions; 4) medical conditions and co-morbidities; and, 5) impairments.

In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) is proposing 15 special services, one of which is a respiratory treatment grouping. Included in that grouping are oxygen therapy (continuous and intermittent), suctioning (scheduled as needed), tracheostomy care, non-invasive mechanical ventilation (BiPAP/CPAP) and invasive mechanical ventilation. Our comments focus on these special services.

Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)

In this category, CMS is proposing oxygen therapy as a principal data element with two sub-elements for Continuous and Intermittent oxygen delivery. "Continuous" is defined as "whether the oxygen was delivered continuously, typically defined as > = 14 hours per day". The elements capture resident use which is reflective of the intensity of care needs, including monitoring and bedside care required. According to the proposed rule, these elements were developed based on similar assessment of oxygen therapy found in MDS 3.0 and OASIS-C2 reporting and an element tested as part of a Post-Acute Care Payment Reform Demonstration (PAC PRD) focused on intensive oxygen therapy defined as "High 0_2 Concentration Delivery System with $Fi0_2$ > 40%"

Comments/Recommendations

- The AARC agrees that the divisions of continuous and intermittent are important reporting indicators. It is mentioned that consideration of "High O_2 Concentration Delivery with > 40%" was tested in the PAC PRD but we do not see that it will be included as a consideration. We feel that High O_2 Delivery Systems SHOULD be included as a subgroup under continuous O_2 therapy. Concentrations of greater than 40% require even more resource use. Additionally any resident on >40% oxygen is more critically ill. There should be differentiation in high flow vs low flow oxygen devices.
- We also recommend that consideration be given to advanced modalities now being used in the PAC arena which include high flow, high humidity devices.

Respiratory Treatment: Suctioning (Scheduled, As needed)

CMS is proposing that Suctioning (Scheduled, as Needed) meets the definition of a standardized data element for special services and proposes that the data element consist of the principal element of suctioning, with the following two sub-elements:. "Scheduled" which is based on a specific frequency of suctioning, such as every hour, and "As needed" which is only when indicated.

Comments/Recommendations

- The AARC strongly disagrees with "scheduled" suctioning. We refer CMS to the AARC Clinical Practice Guidelines on "Endotracheal Suctioning of Mechanically Ventilated Patients with Artificial Airways" (https://www.aarc.org/wp-content/uploads/2014/08/06.10.0758.pdf)

> ***ETS 14.0 FREQUENCY Although the internal lumen of an ETT decreases substantially after a few days of intubation, due to formation of biofilm, suctioning should be performed only when clinically indicated in order to maintain the patency of the artificial airway used. Special consideration should be given to the potential complications associated with the procedure.***
>
> ***ETS 16.0 RECOMMENDATIONS: The following recommendations are made following the Grading of Recommendations Assessment, Development, and***

Evaluation (GRADE)88,89 criteria: 16.1 <u>It is recommended that endotracheal suctioning should be performed only when secretions are present, and not routinely. (1C)</u>

- As the guidelines point out, suctioning should only be performed when clinically indicated. Moreover, suctioning on a scheduled basis when there is no indication of need incentivizes the routine passing of a catheter into the trachea which causes trauma to the mucosal lining, potential infection and other complications.

<u>Respiratory Treatment: Tracheostomy Care</u>

CMS states that this data element is feasible for use in PACs and that it assesses an important treatment that would be clinically useful both within and across PAC provider types.

Comments/Recommendations

- The AARC agrees that tracheostomy care should be included as a data element under the special treatments category.

<u>Respiratory Treatment: Non-Invasive Mechanical Ventilator (BiPAP, CPAP)</u>

CMS is proposing to establish a principal data element Non-invasive Mechanical Ventilator with two sub-elements: BiPAP and CPAP. Although use of these terms is different between the LTCH and SNF setting, CMS is proposing to make the terminology consistent within these settings.

Comments/Recommendations

- The term "Non-invasive Mechanical Ventilator" implies that a ventilator is being utilized to deliver the therapy. It should be clarified the BiPAP/CPAP referred to in the LTACH setting is generally provided as a mode of ventilation using a device FDA approved as a "mechanical ventilator". This is not the same as BiPAP/CPAP commonly referred to in the SNF setting. Therefore, the comparison is inaccurate.
- CPAP/BiPAP in the SNF is delivered primarily by specific devices as would be seen in the home environment that are FDA specified for that modality. The term "Non-invasive Mechanical Ventilator" for these devices in the SNF is not appropriate and will cause extreme confusion in the SNF/Home environment. <u>The AARC recommends using the more appropriate term "Non-invasive ventilation" with the sub-elements of BiPAP and CPAP.</u> This removes the issue of referring to a "ventilator" in the description.
- The use of a mechanical ventilator for delivery of a BiPAP or CPAP mode in a SNF is problematic and prohibited in some states except in high acuity approved sites which have a 24/hour respiratory therapist.

<u>Respiratory Treatment: Invasive Mechanical Ventilation</u>

In proposing Invasive Mechanical Ventilation as a standardized data element consistent with the intent of the IMPACT Act, CMS considered previous comments that supported it appropriateness given the care coordination and care transitions and those comments

that raised questions about its appropriateness given the prevalence of ventilator weaning across PAC providers, concerns about timing of administration, how weaning is defined, and how weaning status relates to quality of care. Based on these comments, CMS decided to go with a single data element which does attempt to capture weaning status.

Comments/Recommendations:

- We would disagree that a single data element of invasive mechanical ventilation be used and recommend that CMS reassess its decision given previous comments related to weaning status. Regardless of the factors, timing of administration, how weaning is defined and how it relates to quality of care, we feel that a data element capturing "weaning" is of significant importance. The fact that weaning is being attempted drives up the utilization of resources regardless of the variable factors.
- It is now commonplace for ventilator weaning to occur in the SNF, especially those with high acuity programs. Lengths of time on and off the ventilator are very important factors. During the time a resident is off the ventilator device and clinical bedside monitoring becomes even more crucial.

The AARC appreciates the opportunity to comment on the SNF FY 2018 update. If you have any questions or desire additional information, please contact Anne Marie Hummel, Associate Executive Director for Advocacy and Government Affairs at anneh@aarc.org or 703-492-9764.

Sincerely,

Brian K. Walsh, PhD, RRT-NPS, RRT-ACCS, AE-C, RPFT, FAARC
President