AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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June 23, 2017

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

Re: CMS-1686-ANPRM: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Revisions to Case-Mix Methodology

Dear Ms. Verma:

As President of the American Association for Respiratory Care, I am pleased to submit comments on the subject proposed rule which addresses revisions to the case-mix methodology and classifications. The AARC is a national professional organization with a membership of over 47,000 respiratory therapists who treat patients with chronic respiratory diseases such as Chronic Obstructive Pulmonary Disease (COPD) and whose organizational activities impact over 170,000 practicing respiratory therapists across the country. Respiratory therapy services including oxygen therapy, inhalation treatment and ventilator management are a vital part of the care furnished by respiratory therapists in the skilled nursing facility (SNF) setting.

One of the issues the Centers for Medicare and Medicaid Services (CMS) has grappled with since the inception of the SNF prospective payment system is how to account for "non-therapy ancillary services" as part of its case-mix methodology. Currently payments for these services are incorporated into the nursing component. However, it has been pointed out that the current methodology does not adequately provide for payments that account for variation in, or the real costs of, things such as drugs, laboratory services, respiratory therapy, medical supplies, prescription drugs and medication therapy and we agree with that conclusion. To address the problem, CMS is considering a methodology to adjust SNF payments to more appropriately reflect differences in NTA costs. Our comments focus on this aspect of the proposed rule.

The AARC strongly supports any methodology that recognizes the resource cost and use of respiratory therapy services in the SNF setting. We were very disappointed when recent changes to include respiratory therapy as a specialized rehabilitation service as part of the reform to policies impacting long-term care facilities did not result in an increase or change in RUG payment classifications. To recognize the impact of non-ancillary services as part of the SNF case-mix methodology is long overdue and we appreciate CMS inviting comment on this important topic.

Respiratory therapists are educated and trained in all aspects of pulmonary medicine and a vital resource to residents of SNFs. These licensed professionals undergo rigorous validated competency testing over the full scope of practice which includes diagnosis, treatment, and management of all respiratory diseases and conditions. They are responsible for management of mechanically ventilated patients, administration of a wide range of prescription medications via aerosol therapy as well as all aspects of oxygen therapy including assessment of the patient's needs, titrating oxygen dosage and selection of the appropriate oxygen delivery devices. Respiratory therapists by virtue of their education are experts in application and management of physician-ordered treatment for respiratory patients and the selection of the appropriate devices such as ventilators and oxygen systems. It is imperative their skills, expertise and resource use be recognized as part of the NTA component of the case-mix methodology.

Conditions and Extensive Services used for NTA Classification

CMS is proposing to establish Non-Therapy Ancillary (NTA) Case-Mix Classification Groups in which all residents would be classified into one group only, following the same methodology used for physical therapy, occupational therapy and speech pathologists components. While we have no specific comments on the algorithms and cost regressions used to develop the new NTA component of the RCS-I case-mix model, we do concur with CMS' proposal to set the case-mix index to reflect case-mix related relative differences in costs across groups to help ensure payment reflects the relative resource use at the per diem level.

In developing a scoring methodology, CMS has proposed a table identifying 1) the condition/extensive service to be considered; 2) the source from which the service was derived; 3) a tier based on resource use such as Ultra-High, Very High, High, Medium and Low; and, 4) points assigned to each service, resulting in six NTA score categories ranging in points from 0 to 11+.

The conditions/extensive services and their tier assignment on CMS' proposed list impacting individuals residing in skilled nursing facilities who suffer from chronic respiratory disease include the following: Ventilator/Respiratory (High), Cystic Fibrosis (Medium), Multiple Sclerosis (Medium), Tracheostomy (Medium), Asthma, COPD or Chronic Lung Disease (Medium), and Suctioning (Low). In reviewing the list, we offer the following comments and recommendations:

Comments/Recommendations:

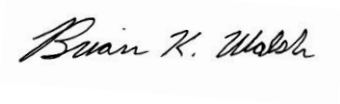
- We recommend the terminology be changed from "ventilator/respirator" to "*Invasive Mechanical Ventilator"*. The term "respirator" is out dated and is generally no longer used.
- In addition to the change in terminology noted above, we recommend "*Invasive Mechanical Ventilator*" be classified in the "Very High" tier rather than the proposed "High" designation. The use of a mechanical ventilator requires the 24 hour presence of a respiratory therapist as well as advanced monitoring equipment. Ventilator weaning is now common and liberation occurs in the SNF setting making the care of this population much more intense.
- We recommend changing "Multiple Sclerosis" to "*Neuromuscular Disease*". This change would then also encompass Duchesne Muscular dystrophy and other neuromuscular disorders commonly seen in the SNF. The needs of this population include intense airway clearance procedures/devices and the intervention of a respiratory therapist.
- Last, we recommend that use of BiPAP/CPAP be included as a "High" tier in the listing as the use of these devices requires specialty equipment and respiratory therapist intervention/monitoring.

As opposed to combining NTA and nursing into one component as in the RUG-IV system, the RCS-I case-mix model CMS proposes would create a separate payment component for NTA services. According to CMS, this separation allows payment to be based on "resident characteristics that predict NTA resource utilization, rather than nursing staff time", and the AARC strongly supports that distinction.

Overall, we agree with CMS' assessment that the proposed NTA case-mix index would be a better measurement of resource use and ultimately result in more accurate payments. It is high time that the importance of respiratory therapy services provided in the SNF setting by skilled respiratory therapists are correctly identified and paid for accordingly.

We appreciate the opportunity to submit comments.

Sincerely,



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