AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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June 18, 2018

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

Re: CMS-1696-P: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program and SNF Quality Reporting Program

Dear Ms. Verma:

As President of the American Association for Respiratory Care, I am pleased to submit comments on the subject proposed rule which would establish a new Patient-Driven Payment Model (PDPM) for Skilled Nursing Facilities (SNFs) effective October 1, 2019. 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 asthma and whose organizational activities impact over 170,000 practicing respiratory therapists across the country. Our comments address the proposed Non-Therapy Ancillary (NTA) Component to be created under the new PDPM model.

Non-Therapy Ancillary (NTA) Services

Respiratory services, such as ventilator management, tracheostomy care, and suctioning among other services, are considered Non-Therapy Ancillary (NTA) services in the SNF setting, yet they are a vital and costly part of the care furnished by respiratory therapists. Other costly NTA services include drugs, lab services and medical supplies. Last year, in an advanced notice of proposed rulemaking (ANPRM), CMS recognized that its current payment methodology did not adequately account for NTA services which had been included as part of the nursing component and whose payment was based on nursing staff time. The agency proposed to develop a new Resource Classification System, Version 1 (RCS-1) to address the issue.

In its FY 2019 update, the PDPM will replace the proposed RCS-1 case-mix methodology and will tie payment to patients' conditions and care needs rather than the volume of services they receive. Similar to the RCS-1 model, the PDPM model will provide for a separate NTA component taking into account comorbidities present at the time the individual is admitted to the SNF and the extensive services provided during the length of stay. A point value will be assigned to such conditions/extensive services with all residents classified into one of six NTA case-mix classification groups based on a scale of 0 to 12+. In the list of conditions/extensive services to be used for NTA classification, we note CMS is still using the term "ventilator or respirator". We urge CMS to remove the term "respirator" in the final rule as it is outdated and a term that is no longer used.

The AARC strongly supports any methodology that recognizes the cost and resource utilization of respiratory therapy services in the SNF setting. In addition to the respiratory conditions/extensive services contained in last year's advance notice and carried over to the proposed FY 2019 update, we also support the addition of Cardio-Respiratory Failure and Shock, Respiratory Arrest and Pulmonary Fibrosis and Other Chronic Lung Disorders to the list used for NTA classification. We are disappointed, however, with some of the point values assigned to some of respiratory services on the list, particularly ventilator care.

In last year's ANPRM, CMS proposed a scoring methodology in which conditions and extensive services were assigned tiers designated as Ultra-High, Very High, High, Medium and Low with points assigned based on the tier designation. At the time, the AARC recommended the assignment of ventilator care in the "Very High" tier with a point value of 7 rather than the proposed "High" designation assigned by CMS which carried a point value of 5. The AARC's rationale for the higher distinction for ventilator care is based on the need for the 24-hour presence of a respiratory therapist as well as advanced monitoring equipment. Moreover, ventilator weaning as noted in our earlier comments is now common, with liberation occurring in the SNF setting, making the care more intense.

Unfortunately, CMS choose not to accept our comments. Further, we note the value assigned to ventilator care in the FY 2019 update is one point lower than proposed in the ANPRM, although CMS is not using the same tier system designation as proposed previously, e.g., Ultra-High, Very High, etc. Nonetheless, we recognize the substantial research CMS conducted in examining the potential for refinements to NTA services and support the overall proposal with respect to the separate NTA component based on the thoroughness with which the PDPM alternative was reviewed and the numerous data sources, algorithms and cost regressions that went into developing the case-mix methodology. Recognizing separately NTA services that include respiratory care rather than combining them with the nursing component is long overdue and a step in the right direction.

General Comments

Last year, when considering the new NTA case-mix component, CMS made a point of eliminating certain NTA services, such as oxygen therapy and non-invasive ventilation (NIV), i.e., BiPAP/CPAP. The rationale was based on the opinion of the clinicians who were part of the research team at the time that these services were easily delivered and prone to overutilization and the costs were most likely captured in the increase in costs associated with asthma, COPD or chronic lung disease, conditions included in the proposed PDPM model. Patients who are utilizing NIV and High Flow O2 therapy devices are higher acuity patients. These modalities are more complex in nature and require the expertise of qualified respiratory therapists who are best educated and competency tested to provide complex respiratory care services. We request CMS take this into consideration as further refinements are made to the PDPM.

We appreciate the opportunity to provide comments on the proposed 2019 SNF update and applaud CMS for proposing a patient-driven payment model comprised of a separate NTA component that more appropriately recognizes the cost and resources of respiratory therapy and other NTA services.

Sincerely,

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