



June 22, 2015

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators Hatch, Wyden, Isakson and Warner:

As leaders of the American Association for Respiratory Care (AARC) and Allergy & Asthma Network (The Network), we applaud the Senate Finance Committee's bipartisan efforts to explore solutions to improve the health outcomes of Medicare beneficiaries living with chronic conditions. The Committee is interested in stakeholder input on several topics. Our comments address two of them:

- Ideas to effectively use or improve use of telehealth and remote monitoring technology;
- Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

The AARC is the leading national and international professional association with a membership of 50,000 respiratory therapists who treat patients with chronic lung disease and whose organizational activities impact approximately 175,000 practicing respiratory therapists nationwide. The AARC encourages and promotes professional excellence, advances the science and practice of respiratory care, and serves as an advocate for patients, their families, the public, the profession and respiratory therapists.

The Network is the leading nonprofit organization whose mission is to end the needless death and suffering due to asthma, allergies and related conditions through outreach, education, advocacy and research. It is comprised of a multidisciplinary community of healthcare professionals, patients, families, industry and government decision makers dedicated to improving health and quality of life for people with asthma or allergies. An innovator in encouraging patients and families to participate in and take responsibility for treatment plans,

The Network specializes in making accurate medical information relevant and understandable to all, while promoting standards of care that are proven to work.

Background

CMS' Chronic Conditions website (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html>) provides national, state and county statistics on Medicare beneficiaries with multiple chronic conditions. Prevalence of the disease, Medicare utilization (e.g., hospital readmissions and emergency department visits) and actual per capita spending per beneficiary are grouped into four categories based on the number of multiple chronic conditions (e.g., 0-1, 2-3, 4-5 and 6 or more). Seventeen chronic conditions are tracked for the years 2008 through 2012.

Chronic Obstructive Pulmonary Disease (COPD) and asthma are two of the 17 chronic conditions that are tracked. While the national prevalence of these diseases among Medicare beneficiaries appears to be somewhat small (e.g., 11.9% and 4.8%, respectively) in comparison to other chronic conditions such as hypertension (55.49%) or arthritis (28.96%), it is important to note that 52% of Medicare beneficiaries with COPD have 5 or more other conditions while 47% of those with asthma have 5 or more conditions. Although per capita spending is not broken out by disease, it is available based on the number of multiple chronic conditions. According to the data for 2012, the per capita amount Medicare spent on those with 6 or more chronic conditions was \$32,626.

Last October COPD was added to the list of conditions subject to the Hospital Readmissions Program. This action was based largely on recommendations by the Medicare Payment Advisory Commission that listed COPD as the fourth most costly diagnosis in terms of readmissions in its 2007 Report to Congress titled "Promoting Greater Efficiency in Medicare."¹ Further, COPD and asthma were listed among the 10 most costly health conditions at of cost of \$75 billion in 2011 according to data from the Agency for Healthcare Research and Quality as reported by the Wall Street Journal.²

Telehealth and Remote Patient Monitoring

- **Reform measures regarding telehealth should include coverage of respiratory services and qualified telehealth professionals including respiratory therapists that are contained in the language of the Medicare Telehealth Parity Act.**
- **Revisions to the statute should also include coverage of remote patient monitoring for Medicare patients with chronic conditions such as COPD and an individual's home as a telehealth site.**

The AARC and The Network as part of the Alliance for Connected Care are partners in a multi-stakeholder group that supports reform of Medicare's approach to telehealth and remote patient monitoring services for patients with chronic conditions. In that regard, we have signed on to joint comments that recommend Congress take actions to: 1) establish a remote patient monitoring benefit; 2) ensure improvements to chronic care management, such as telehealth and remote patient monitoring, are applied widely to Medicare system components such as the Medicare Shared Savings Program and Accountable Care Organizations; 3) direct the Centers for Medicare and Medicaid Services to properly collect and use data on the benefits of telehealth and remote patient monitoring; 4) reform patient categories most in need, such as

dual eligibles; 5) instruct CMS to develop an approach to ensure quality and continuity of care that telehealth and remote patient monitoring provide; and 6) prioritize interoperability consistent with voluntary industry standards currently utilized in commercial products. In addition to the joint stakeholder comments, the AARC and The Network offer additional input and recommendations that address the specific needs of Medicare patients with chronic lung disease.

Our organizations strongly support legislative language contained in the Medicare Telehealth Parity, a bill (HR 5380) sponsored by Congressmen Thompson and Harper and introduced in the 113th Congress. The bill is expected to be reintroduced shortly. Among the provisions, the bill includes 1) respiratory therapists as qualified telehealth professionals among other therapy providers; 2) respiratory services, physical therapy, plus other therapies as covered telehealth services; 3) an individual's home as a telehealth site in conjunction with home health, hospice care, home dialysis and durable medical equipment; and, 4) remote patient monitoring services for chronic conditions including COPD and heart failure. With COPD listed as the third leading cause of death by the Centers for Disease Control and Prevention, access to respiratory therapists via telehealth for Medicare beneficiaries with chronic lung disease adds another dimension toward improving care and reducing hospital readmissions.

Currently, the only practitioners recognized by Medicare qualified to provide telehealth services are physicians, nurse practitioners, physician assistants, certified nurse specialists, nurse-midwives, clinical psychologists, clinical social workers and registered dietitians or nutrition professionals. It is important to include respiratory therapists as telehealth professionals because Medicare beneficiaries trained by these experts to recognize and reduce symptoms and triggers of their chronic disease can reduce exacerbations and lower the incidence of costly acute care interventions as well as improve medication adherence and oxygen utilization for those Medicare beneficiaries who require oxygen.

The Competitive Bidding Program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, e.g., positive airway assist devices, oxygen and oxygen equipment, has resulted in reduced access to respiratory therapists to go into the home to ensure proper use of inhalation and/or oxygen devices. To improve access to respiratory therapists, by including an individual's home as a covered telehealth site, can help patients to better manage their disease through telehealth self-management education and training on the proper techniques when using their devices to ensure adherence and maximum effectiveness.

As noted further in these comments, respiratory therapists are already making a difference in their hospitals by establishing best practices that reduce COPD readmissions. These successful strategies can also be applied via a telehealth delivery system. If the Chronic Care Working Group requires more detailed information on these practices, please contact Tom Kallstrom, Executive Director/CEO, AARC, at kallstrom@aac.org.

There are numerous studies related to respiratory care and training to teach patients how to manage their chronic lung disease via telehealth that show these types of services are beneficial in lowering costs and improving quality of life. A few of these are discussed below.

- Certain Medicare beneficiaries with COPD who were enrolled in a telehealth system combined with care management designed to enhance patient education, self-management,

and timely access to care were associated with 23% lower quarterly all-cause hospital admissions and 40% lower quarterly respiratory-related hospital admissions.³

- In an analysis of ten clinical trials, telehealth for COPD showed a significant reduction in the number of patients with one or more emergency department (ED) visits over 12 months. The analysis concluded that telehealth appears to have a positive impact on quality of life and the number of times patients are admitted to the ED or hospital.⁴
- Twenty-one trials were evaluated to assess the effectiveness of telehealth interventions in individuals with asthma. There was a significant reduction in hospitalizations for patients with more severe asthma managed predominantly in secondary care settings.⁵
- Home telehealth for elderly, severe COPD patients with multiple comorbidities reduced emergency room visits, hospitalizations, length of stay, and need for non-invasive mechanical ventilation after 7 months of monitoring.⁶

Empowering Medicare Beneficiaries to Better Manage their Health and Engage with their Health Care Providers

- **Reform measures should include separate payment for self-management education and training when furnished by respiratory therapists in a physician's practice to Medicare patients who suffer from chronic lung disease.**

Over a decade ago, Congress enacted a law that provided separate payment for self-management training for diabetes patients which has proven successful in improving patient outcomes. Unfortunately, the current Medicare fee-for-service payment structure only covers self-management services when bundled with other services, even though separate codes exist to identify the services. Recent coverage of transitional care and chronic care management services are designed to improve health and keep patients out of the hospital, but they do not go far enough because a patient's self-management of their disease is expected to be carried out non-face-to-face and bundled with a variety of other services that comprise these benefits.

Transitional care management services "provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living and activities of daily living." Chronic care management services require "medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications." Neither of these services adequately addresses the unique needs of pulmonary patients and the variety and complexity of devices such as aerosol inhalers and oxygen systems used to treat their chronic lung disease.

Respiratory therapists comprise the only health care profession that receives comprehensive formal education in all aspects of pulmonary medicine. 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 and testing 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.

Unlike physical therapists, occupational therapists, speech-language pathologists, and certified diabetes educators, respiratory therapists are not recognized in the Medicare statute. In today's environment, the majority of respiratory therapists work in the inpatient acute care setting. This is due largely to the fact that the primary Medicare Part B category that permits them to work in a physician's practice, for example, is limited to the statute's "incident to" category.

The current "incident to" benefit category defines services as those that are 1) an integral, although incidental, part of the physician's professional service; 2) commonly rendered without charge or included in the physician's bill; 3) are of a type that are commonly furnished in physician's offices or clinics; and 4) are furnished by physicians or by auxiliary personnel under the physician's direct supervision. The Medicare program does little to incentivize physicians to hire respiratory therapists in their practice, especially pulmonologists whose primary focus is on patients with chronic lung disease, because there is no guarantee that Medicare will pay the physician for the respiratory therapists' services outside of the general evaluation and management services rendered to the patient during an office visit, thus limiting access to their expertise in this setting.

With physician shortages expected to continue and worsen over time, the need to incorporate a team of qualified, competent staff in the physician practice that includes respiratory therapists is greater than ever. This is especially important as increased emphasis is placed on the transition from hospital to home, improved care coordination, and the need for patients to follow-up with their physician post-discharge.

Proper Education and Training Can Improve Medication Adherence and Oxygen Utilization

Medication non-adherence has been estimated to cost the US health care system between \$100 billion and \$289 billion in direct costs according to an Evidence Report/Technology Assessment conducted by the Agency for Healthcare Research and Quality.⁷ The report cites studies that provide strong evidence suggesting "benefits attributable to improved self-management of chronic diseases could result in a cost-to-savings ratio of approximately 1:10."

Patient education and proper device selection for both inhalers and oxygen systems are critical for optimal clinical outcomes and cost effectiveness for patients with chronic lung disease. Respiratory therapists are experts in this field and the time they can spend with the patient to assist the physician can be invaluable. Due to the complexities of inhaler devices and oxygen systems, respiratory therapists' expertise is needed in order to minimize unnecessary, ineffective or wasteful interventions. For example, it is important for the patient to be educated on the nuances of portable oxygen concentrators that have very different settings depending on the manufacturer and to be knowledgeable of the differences between intermittent and continuous flow.

- A 2010 study comparing the clinical performance of oxygen-conserving devices found the systems to be highly variable leading to inconsistencies that interfere with oxygenation during exertion and contribute to limitations in patient exercise ability.⁸
- 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.⁹

- Upfront investment of personnel in patient training in inhaler techniques can save time and resources by preventing uncontrolled exacerbations because of poor technique.¹⁰

Self-management Education and Training Can Lower Costs and Improve Health Outcomes

Medicare patients who properly self-manage their chronic lung disease working with respiratory therapists can also slow their disease progression and improve health status. Self-management teaches patients to recognize and reduce the symptoms and triggers of their chronic lung disease which can lead to reduced exacerbations and lower the cost of acute care.

- 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%.¹¹
- The National Asthma Guidelines include self-management education as an integral component of asthma care, highlighting the need to teach and reinforce at each visit to ensure correct inhaler technique and use of devices.¹²
- 50,000 older adults, most with multiple chronic conditions, benefited by improved symptom control, improved quality of life and reduced emergency room visits and hospital days as part of the Administration on Aging Chronic Disease Self-Management Program.¹³
- As part of its Strategic Framework for Multiple Chronic Conditions, the Department of Health and Human Services includes maximizing the use of proven self-care management as one of its goals.¹⁴
- Scientific studies show that self-management education can reduce urgent care visits and hospitalizations and improve health status.^{15, 16}
- Respiratory therapists as asthma disease-management educators and respiratory care managers report successful outcomes in reducing emergency department visits and hospitalizations.¹⁷

As mentioned earlier, respiratory therapists are developing best practices in their hospitals that result in reduced COPD readmissions. For example, one hospital's COPD readmission rate went from 28% to 7% when respiratory therapists utilized sound disease management practices. Improving access to their expertise in the physician's practice can help prevent returns to the hospital by providing incentives for physicians to receive separate payment for self-management education and training services when furnished by respiratory therapists for their pulmonary patients.

Summary

Medicare patients with multiple chronic conditions such as COPD and asthma are costly and prevalent. Given the opportunity through legislative reform, increased access to respiratory therapists via telehealth and in physician practices can improve the health outcomes of those who suffer from chronic lung disease while reducing hospital readmissions and lowering costs.

By virtue of their education, training and competency testing, respiratory therapists are the only allied health professionals with expertise in all facets of pulmonary medicine. The lack of recognition of their skills in the Medicare statute limits their exposure outside the hospital setting and is a major drawback in the ability of Medicare patients with pulmonary disease to access their services post-discharge.

Numerous studies show that patient self-management can improve health outcomes and quality of life and is cost effective; yet, Medicare provides separate payment for these services only when they are furnished to diabetes patients by certified diabetes educators. Because coverage of self-management is reimbursed by and large as part of other bundled services, it does not address the needs of pulmonary patients who often rely on complex devices to keep them alive and who often misuse or do not adhere to their treatment regimen through lack of understanding. Current transitional care management services and chronic care management services do not go far enough to address these problems.

As the Senate Finance Committee's Chronic Care Working Group tackles reform measures to improve health outcomes for Medicare patients suffering from chronic conditions, the AARC and The Network offer the follow recommendations:

Recommendations

Telehealth

- Reform activities involving improvements and/or expansion of Medicare telehealth services should include statutory language that identifies respiratory therapists as professionals qualified to furnish telehealth services as well as provide management and evaluation of remote patient monitoring services for Medicare patients with chronic conditions that include COPD
- Respiratory services should be added to the list of covered telehealth services.
- Telehealth services should also include an individual's home as a telehealth site in conjunction with services provided as part of home health, home dialysis, hospice care and durable medical equipment.

Patient Self-Management

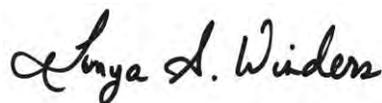
- The Medicare statute should be revised to add separate payment for self-management education and training services when furnished by respiratory therapists in a physician's practice to Medicare patients who suffer from chronic lung disease, consistent with previous Congressional actions that added diabetes outpatient self-training as a separate Medicare benefit.

The AARC and The Network appreciate the opportunity as interested stakeholders to provide input that will be useful to the Chronic Care Working Group as Medicare reforms are taken into consideration.

Sincerely,



Frank R. Salvatore, RRT, MBA, FAARC
President
American Association for Respiratory Care



Tonya A Winders, MBA
President & CEO
Allergy & Asthma Network

References

- 1 Medicare Payment Advisory Commission: Report to the Congress "Promoting Greater Efficiency in Medicare." June 2007. Chapter 5: *Payment policy for inpatient readmissions*. Table 5-3, page 116.
- 2 Wall Street Journal, February 24, 2014. How Health-Care Spending Got So High. Data source: Agency for Healthcare Research and Quality.
- 3 Au DH, et al. Impact of a Telehealth and Care Management Program for Patients with Chronic Obstructive Pulmonary Disease. *Annals ATS*. First published online 02 Feb 2015 as doi: 10.1513/AnnalsATS.201501-042OC.
- 4 McLean, et al. Telehealthcare for chronic obstructive pulmonary disease. *Cochrane Database Syst Rev*. 2011 Jul 6;(7):CD007718. doi:10.1002/14651858.CD997718.pub2
- 5 McLean, et al. Telehealthcare for asthma. *Cochrane Database Syst Rev*. 2010 Oct 6;(10):CD007717. doi: 10.1002/14651858:CD007717.pub 2
- 6 Segrelles Calvo, G, et al. A home telehealth program for patients with severe COPD: The PROMETE study. *Resp Med*. Volume 108, Issue 3, March 2014, Pages 453-462. doi:10.1016/j.rmed.2013.12.003.
- 7 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
- 8 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.
- 9 Chaney, JC, et al. Implementation of an Oxygen Therapy Clinic to Manage Users of Long-term Oxygen Therapy. *Chest* 2002;122:1661-1667)
- 10 Papi A, et al. Editorial: Inhaler devices for asthma: a call for action in a neglected field. *Euro Respir J* 2011;37:982-985.
- 11 Rice KL, et al. Disease management program for chronic obstructive pulmonary disease: a randomized controlled trial. *Am J Respir Crit Care Med* 2010 Oct 1;182(7):890-6. DOI: 10:1164/rccm200910-1579OC. Epub 2010 Jan 14
- 12 Guidelines for the Diagnosis and Management of Asthma. National Asthma Education and Prevention Program, Expert Panel Report 3. NIH Publication No. 08-5846. October 2007.
- 13 HHS Strategic Framework on Multiple Chronic Conditions One-Year Anniversary press release. Available at www.hhs.gov/news/press/2011/pres/12/20111214n.html
- 14 Multiple Chronic Conditions: A Strategic Framework. Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. US Dept. of Health and Human Services. Dec. 2010.
- 15 Lorig, KR, et al. Chronic Disease self-management program: 2-year health status and health care utilization outcomes. *Med Care* 2001 Nov;39(11):1217-23.
- 16 Effig T., et al. Self-management education for patients with chronic obstructive pulmonary disease. *Cochrane Database Syst. Rev*. 2007. Oct 17;(4):CD002990.
- 17 Making a Difference in the Management of Asthma: A Guide for Respiratory Therapists. NIH Publication No. 02-1964. May 2003