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January 27, 2016

Bipartisan Chronic Care Working Group
Senate Finance Committee
U.S. Senate
Washington, DC 20510

Dear Sens. Isakson and Warner:

On behalf of the American Thoracic Society (ATS), I would like to submit our recommendations in response to Bipartisan Chronic Care Working Group's Policy Options Document. The ATS is a 15,000 member scientific medical organization dedicated to the prevention, detection, treatment and cure of respiratory disease, critical illness and sleep related disorders through research, clinical care and advocacy. We focus on respiratory health issues, including asthma, chronic obstructive pulmonary disease (COPD), pneumonia, sepsis and sleep-disordered breathing.

Respiratory diseases, critical illnesses and sleep disorders represent a significant portion of the chronic care burden in the U.S. COPD is the third leading cause of the death in the U.S.[i] Its death rate has doubled within the last 30 years and is still increasing, while the rates for the other leading causes of death (heart disease, cancer and stroke) have decreased by over 50 percent. The Centers for Disease Control and Prevention (CDC) estimates that 24 million Americans have COPD but 12 million don't know that they have the disease. COPD costs the economy almost $50 billion a year, including $29 billion in direct medical costs and $20.4 billion in indirect costs such as lost wages.[ii] Almost 26 million Americans have asthma and it is the most common chronic disorder in children, with an estimated 7 million children currently affected.[iii] Finally, the CDC estimates that 50 – 70 million Americans have a sleep disorder.[iv] The long-term health consequences of sleep disorders such as obstructive sleep apnea (OSA) and insomnia include increased risk of hypertension, cardiovascular disease and obesity. We have the following recommendations to ensure better care coordination and management of chronic respiratory diseases, critical illnesses and sleep disorders.

Advancing Team Based Care

The ATS agrees that interdisciplinary health teams can improve patient outcomes and we believe that some of the policy proposals outlined in this section of the policy document, such as the provision of hospice benefits to Medicare Advantage enrollees and the creation of a new payment code for high-severity chronic care payment code have the potential to improve care for patients with chronic conditions. The ATS recommends that respiratory therapists be included as part of chronic care management teams, particularly for those patients with chronic respiratory disease. Respiratory therapists are specifically trained to evaluate and manage patients who have respiratory illnesses, including those that are often associated with significant disability such as COPD, asthma and interstitial lung disease. Their expertise will help to ensure a total management package for these patients.

DME Access for Patients with Chronic Conditions

Access to durable medical equipment (DME) for at-home use by patients with chronic respiratory diseases is currently an unmet need for some adults and children with respiratory diseases such as COPD, interstitial lung disease/ pulmonary fibrosis, neuromuscular diseases, infants with chronic lung disease of prematurity, survivors of Acute Respiratory Distress Syndrome (ARDS) and sleep disorders including sleep apnea. DME includes home mechanical ventilators, Respiratory Assist Devices (RADs) including non-invasive ventilatory equipment, oxygen delivery devices and nebulizers. Many affected patients also require DME to facilitate mucus clearance including external percussion devices, cough assist devices and suction equipment.

The number of patients requiring prolonged mechanical ventilation in the U.S. is rapidly increasing. Improved intensive care unit (ICU) treatment has enabled more patients to survive acute respiratory failure and require prolonged mechanical ventilation during convalescence. In addition, mechanical ventilation is increasingly used as a therapeutic option for patients with symptomatic chronic hypoventilation. Long-term mechanical ventilation at home, rather than the hospital, can significantly reduce healthcare costs and enhance patient quality of life.[v] Home mechanical ventilation also reduces exposure to hospital-borne infections and frees hospital ICU beds for other acutely ill patients. Unfortunately barriers to effective home ventilation, including a lack of insurance coverage/reimbursement and caregiver training may lead to recurrent hospitalizations for pneumonia or exacerbations of the underlying disease. The ATS urges the Working Group to ensure that adequate reimbursement for DME and caregiver support is available so that the healthcare system cost and quality of life benefits of home ventilation can be maximized.

75% Rule on Acute Rehabilitation

Patients require ICU-level care for common medical conditions such as severe pneumonia, exacerbations of asthma and COPD, heart failure, sepsis, and acute kidney injury. Survival rates for patients who require ICU care has improved substantially over the past 20 years. But survivors of critical illness are often faced with profound functional deficits secondary to polyneuropathy and critical illness myopathy. Up to 65% of ICU survivors have functional limitations after discharge from the hospital and these functional disabilities have been shown to persist as long as 5 years.[vi]

A major focus for ICU clinicians and researchers is to decrease the effect of critical illness on patients' functional status. Studies have shown that interventions in the ICU, such as early mobilization and physical therapy, have been shown to have a significant impact on patients' functional status at hospital discharge.[vii] However, the ability to discharge critical illness survivors who do not have an independent functional status at discharge, but have a high potential to benefit from aggressive physical therapy to acute rehabilitation settings is significantly limited by the Centers for Medicare and Medicaid Services "75% rule". This rule requires acute rehabilitation hospitals to maintain 75% of their patient population from a group of 13 diagnoses. Respiratory and critical illnesses such as pneumonia, COPD and sepsis are not included in the list of eligible diagnoses. Expanding the list of eligible diagnoses to include those recovering from critical illness has the potential to significantly improve the functional status of patients with these illnesses and reduce their long term chronic care needs. The ATS urges the Working Group to include a provision in its upcoming chronic care legislation to expand the 75% rule on acute rehabilitation to include COPD, asthma, pneumonia, ARDS and sepsis.

Prevention of Chronic Respiratory Conditions

Cigarette smoking is a leading cause of chronic respiratory and cardiovascular diseases, including COPD, lung cancer and heart disease. Open access to treatment for tobacco dependence reduces the incidence and severity of chronic diseases associated with smoking, significantly reduces future health system costs, even in the short term, and improves quality of life.[viii] Tobacco cessation treatment has received an "A" rating from the U.S. Preventive Services Task Force. Medicare covers 80% of tobacco cessation counseling after a deductible has been met for people diagnosed with a disease or condition caused by smoking, which can be a financial hardship for some beneficiaries. Medicaid coverage of tobacco cessation services varies significantly by state. To continue to reduce tobacco use nationally, we must ensure that all Americans have open access to comprehensive tobacco cessation services without copays, deductibles or limits through Medicare, Medicaid and private health insurance. We strongly recommend that the Working Group include expanded access to treatment for tobacco dependence in its chronic care legislation.

Thank you for your consideration of our recommendations. If you have any questions, please Contact Nuala Moore, Associate Director of Government Relations at 202.296.9770 or Nmoore@thoracic.org.

Sincerely,

Atul Malhotra, M.D.
President
American Thoracic Society

[i] Centers for Disease Control and Prevention. NCHS National Health Interview Survey Raw Data, 2008.
[ii] National Heart, Lung and Blood Institute Fact Book 2012.
[iii] Ibid.
[iv] Institute of Medicine. *Sleep Disorders and Sleep Deprivation: An Unmet Public Health Problem*. Washington, DC: The National Academies Press; 2006.
[v] King, AC. Long Term Mechanical Ventilation in the United States. Respir. Care 2012. (57) 6: 921 – 929.
[vi] Herridge MS, Tansey CM, Matte A, et al. Functional disability 5 years after acute respiratory distress syndrome. N Engl J Med 2011;364:1293-1304.
[vii] Schweickert WD, Pohlman MC, Pohlman AS, et al. Early physical and occupational therapy in mechanically ventilated, critically ill patients: a randomised controlled trial. Lancet 2009;373:1874-1882.
[viii] Richard P, West K, Ku L (2012) The Return of Investment of a Medicaid Tobacco Cessation Program in Massachusetts. PLoS ONE 7(1): e29665.