

December 1, 2016

Physician-Focused Payment Model Technical Advisory Committee  
C/O U.S. DHHS Asst. Secretary of Planning and Evaluation Office of Health Policy  
200 Independence Avenue S.W.  
Washington, D.C. 20201  
PTAC@hhs.gov

Re: The COPD and Asthma Monitoring Project

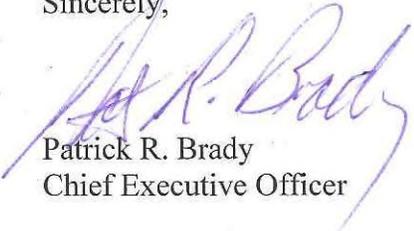
To Whom It May Concern:

It is my pleasure to write this letter in support of the payment model application being submitted by Dr. Daniel Ikeda of Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group to implement COPD and Asthma Monitoring Program (CAMP) – a computerized decision support model designed to leverage the expertise of pulmonary clinicians and to reduce ED visits and hospitalizations related to chronic obstructive airway diseases. It is my belief that the big dollars to be saved in health care are in better managing those with chronic disease.

Pulmonary Medicine Associates (PMA) physicians have served our community for more than 40 years. With more than 30 physicians and non-physician providers, it is the largest group of its kind in California. PMA providers care for some of the most complicated and critically ill patients in the greater Sacramento area, both in the hospital and in the outpatient office setting. Under this proposal, PMA providers would be leveraged, delivering daily evidence-based patient care management strategies to people with chronic obstructive airway diseases all over the state. Using an electronic infrastructure in collaboration with patients, they would be able to deliver a level of care not currently available to most patients with respiratory disease.

I strongly support the goals of CAMP. I am confident in Dr. Ikeda and PMA's ability to deliver the results they promise; that the project will result in new information that will be beneficial for improving asthma and COPD control and lives for patients across the country; and that total cost of health care for this population will be reduced.

Sincerely,

  
Patrick R. Brady  
Chief Executive Officer



AMERICAN ASSOCIATION FOR RESPIRATORY CARE  
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January 5, 2017

Physician-Focused Payment Model Technical Advisory Committee  
U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation, Office of Health Policy  
200 Independence Avenue, SW  
Washington, DC 20201  
[PTAC@hhs.gov](mailto:PTAC@hhs.gov)

RE: The COPD and Asthma Monitoring Project

To Whom It May Concern:

The American Association for Respiratory Care (AARC) is pleased to provide comments on the proposal by the Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group of Sacramento, CA to implement an innovative payment model that remotely monitors Medicare beneficiaries with Chronic Obstructive Pulmonary Disease (COPD) and asthma via digital peak flow meters. The model is designed to improve patient safety and quality of care and reduce health care expenditures through reduced emergency room visits and subsequent hospitalizations

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 asthma and Chronic Obstructive Pulmonary Disease (COPD) and whose organizational activities impact over 170,000 practicing respiratory therapists across the country. The AARC is especially supportive of expanding opportunities for respiratory patients to receive telehealth and remote patient monitoring (RPM) services.

As a member of a large multi-stakeholder Telehealth/RPM Coalition, the AARC has supported and encouraged numerous Congressional activities to increase coverage of telehealth and RPM, especially in conjunction with alternative payment models and expanded services as part of Medicare Advantage plans. Most notably, the AARC is an advocate for including respiratory therapists as telehealth providers, a provision of H.R. 2948, the Medicare Telehealth Parity Act. In addition, the bill adds Medicare coverage of respiratory services, includes an individual's

home as a telehealth site, and provides incremental coverage of RPM services for certain chronic conditions such as COPD and diabetes and related chronic comorbidities when the patient is under Medicare’s chronic care management services.

According to the proposal, the COPD and Asthma Monitoring Project (CAMP) will use a smartphone app (i.e., peak flow meter) and “operate a remote monitoring center supported by specially-trained providers who will track member input into the app and engage participants via voice phone, secure text messaging, email and video conferencing.” As part of the program, CAMP participants will be trained and provided written instructions on the use of the peak flow meter phone app. Data generated by the app will be color coded (e.g., American Lung Association Asthma Action Plan Color Coded Template – Green, Yellow, Red) and sent to a CAMP central server. Patients can access the command center at any time and all Red Zone alerts will initiate a phone call from a representative at the center to the patient if the patient doesn’t call the center first.

The CAMP proposal identifies several studies that support this type of initiative. Another key study<sup>1</sup> that may be of interest to the Technical Advisory Committee is the Health Buddy Program, a content-driven telehealth system coupled with care management designed to enhance patient education, self-management, and timely access to care. Medicare beneficiaries participated through a demonstration project run by the Centers for Medicare and Medicaid Services from 2006 to 2010. The Health Buddy device asked patient questions related to vital signs and disease symptoms and provided feedback and educational information based on question responses. The program was associated with 23% lower quarterly all-cause hospital admissions and 40% lower quarterly respiratory-related hospital admissions. In a subgroup analysis, patients engaged in the intervention during the study period demonstrated significantly lower quarterly hospital admissions for COPD exacerbations.

Using experience gained from a command center associated with Sutter Health in California, CAMP expects its center to include physicians and nurse practitioners to interact with the Medicare beneficiaries with support staff that includes a command center manager and ancillary personnel that may include “medical assistants and secretarial personnel.” In addition, the program intends to hire a psychologist to “create tools to evaluate and suggest ways to increase beneficiary ownership of their disease state. While it may be assumed that respiratory therapists will be key drivers of this program, **we would caution the Technical Advisory Committee to query the proposal’s sponsor to ensure that respiratory therapists have a key role in the payment model before a final decision is reached on whether to**

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<sup>1</sup> Au, DH, Macaulay, DS, et al. Impact of a telehealth and care management program for patients with chronic obstructive pulmonary disease. *Annals Am Thorac Soc*. 2015 Mar;12(3):323-31. <https://dx.doi.org/10.1513/AnnalsATS.201501-042OC>.

**recommend approval.** For example, respiratory therapists are experts in evaluating results from Peak Flow Meters as opposed to medical assistants who do not have comparable education and training. Further, the AARC recommends considering a respiratory therapist to serve as the command center manager.

We support the CAMP design to encourage better disease management especially to empower patients to become more self-aware managers of their own disease. To this end, CAMP will use tools of “education, proactive monitoring, ongoing communication, early recognition, and intervention to ‘move the needle’ in the chronic management of COPD.” Process measures include the following elements to achieve “optimal” COPD and asthma care.

- Assessment and classification of COPD and asthma control using a validated instrument.
- Stepwise approach to identify treatment options and adjust medication and other therapies.
- Written patient self-management asthma action plan customized to take advantage of real-time monitoring and early detection/interventional protocols.
- Patients >4 years of age with flu shot (or flu shot recommendation).
- Smoking cessation and advice where appropriate.

**These are achievable measures as long as the plan includes the expertise of respiratory therapists; however the proposal is silent with respect to their inclusion in the payment model.** The proposal also lays out plans to include participants in a web-based, classroom-style, individualized COPD/asthma education course and smoking cessation course and families are encouraged to participate with the participant in this process. **Based on the skills and expertise of respiratory therapists in providing disease management services to COPD and asthma patients, we strongly recommend the model clearly indicate that such course will be led by a qualified respiratory therapist.**

Respiratory therapists are trained, educated and competency tested in all aspects of pulmonary medicine and their expertise is essential to a program such as CAMP. Further, respiratory therapists’ expertise in the type of disease management program below can help achieve the process measures outlined in the proposal that can lead to improved access to care, improved health outcomes and reduced hospital readmissions:

- Education on self-management of the patient’s disease;
- Education and training in the use of prescribed self-monitoring devices such as peak flow measurement and pulse oximetry;
- Education and training on the proper technique for use of aerosol medications with nebulizers, metered-dose inhalers, and dry-powdered inhalers;

- Direct observation and assessment of the patient’s ability to self-administer aerosol medications;
- Smoking cessation counseling;
- Education and training on compliance with medications and respiratory devices such as oxygen equipment and nebulizers; and,
- Development of an action plan that enables patients to recognize the appropriate response to self-managing their chronic disease according to their symptoms.

While the CAMP proposal appears to be a very ambitious project, it nonetheless has merit, especially since it will implement the NHLBI Guidelines Expert Panel Report 3 – Guidelines for the Diagnosis and Management of Asthma as well as strategy recommendations from the Global Initiative for Chronic Obstructive Lung Disease. As the high cost of treating patients with COPD and asthma continues to rise, especially as these patients often present with multiple chronic conditions, the Medicare program has been deficient in expanding coverage of telehealth and remote patient monitoring (RPM) services which have been demonstrated to improve outcomes and lower costs, as documented in the proposal.

Overall, the proposal is well-designed and has the potential to improve the lives of those who suffer from COPD and asthma. Remote patient monitoring has proven results and should be encouraged to monitor these patients, but we cannot emphasize enough the value of respiratory therapists as part of this initiative. **The AARC recommends the Physician-Focused Payment Model Technical Advisory Committee ensure participants in the CAMP program have access to the expertise of skilled respiratory therapists prior to any formal recommendation on the proposal.**

We appreciate the opportunity to provide into this important endeavor.

Sincerely,



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



January 12, 2017

Physician-Focused Payment Model Technical Advisory Committee  
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy  
200 Independence Avenue S.W.  
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[PTAC@hhs.gov](mailto:PTAC@hhs.gov)

### **Public Comment – The COPD and Asthma Monitoring Project**

Dear Committee Members,

On behalf of The American College of Allergy, Asthma & Immunology (ACAAI) and the Advocacy Council of ACAAI (AC), we appreciate the opportunity to comment on the asthma/chronic obstructive pulmonary disease (COPD) alternate payment model (APM) submitted to PTAC entitled, “The COPD and Asthma Monitoring Project (CAMP).” The ACAAI and the AC are professional medical organizations of more than 6,000 allergists-immunologists and allied health professionals.

The proposed model submitted by Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. of Sacramento, California is a well written and comprehensive proposal centered around a robust, technology driven, system of very close monitoring and rapid intervention for individuals with COPD and asthma. We, too, are in the process of developing and testing an APM for asthma and plan to submit a Letter of Intent soon.

Although the CAMP proposal may have opportunity for cost saving, its design appears to be more that of disease management with close monitoring and, as the authors point out, “(it) **will not replace existing payment models**, but be an added new service.” We thought it would be useful to differentiate our APM for asthma care, which we expect to submit sometime this summer, from the CAMP proposal. Our proposal will be a novel approach to currently existing, volume driven, payment models. It addresses issues including payment and quality standards in asthma management, specifically excluding other asthma-like conditions including COPD. Similar to the CAMP proposal, payments involve risk-sharing and would be stratified by patient characteristics such as diagnosis, severity of symptoms, and comorbidities. The payment model, which is based on a bundled care payment, will look at three different categories of payment, including the initial evaluation of patients with asthma-like symptoms; management of well-controlled asthma; and management of more difficult-to-control asthma.

We believe that although there is clear and well understood crossover between COPD and asthma, they are in many ways very different disease states, and therefore worthy of distinct separation with regard to payment models. Additionally, we believe that the allergic, and not just seasonal component of the disease requires strong consideration both in initial evaluation, but also in long-term management payment models.

In conclusion, we believe that there is considerable potential for cost saving using the CAMP proposal. However, we do not see it as a new method of reimbursement. Its utility would be best suited for the COPD disease population with less applicability to the diagnosis and management of asthma. We hope that our AC/ACAAI asthma APM will fulfill the critical need for a more value driven, less volume-based model for asthma reimbursement.

Respectfully submitted,



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