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August 31, 2016

Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1656-P: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcomes Measures and Document Requirements; Electronic Health Record (HER) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program; Proposed Rule

Dear Mr. Slavitt:

The American Association for Respiratory Care (AARC) appreciates the opportunity to comment on the proposed rule which was published in the Federal Register on July 14, 2016. The AARC is a national professional organization with a membership of 50,000 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.

Our comments focus on the 2017 proposed payment rate for pulmonary rehabilitation services and proposed changes related to payment for certain items and services furnished by certain off-campus departments of a provider as outlined in Section X. A. relating to implementation of Section 603 of the Bipartisan Budget Act of 2015.

Pulmonary Rehabilitation Payment Rate

The AARC is encouraged by the proposed calendar year 2017 payment rate for pulmonary rehabilitation services furnished in the hospital outpatient setting. When the program began in 2010 and CMS first established rates based on proxy data, it was clear that hospitals did not

understand fully how to appropriately submit charges for the bundled payment associated with code G0424, since many of the services previously billed separately were included in the single payment amount. Subsequent to that time, the AARC, together with our sister pulmonary organizations developed a toolkit to assist hospitals in establishing appropriate charges. We believe that this guidance, in part, has helped hospitals to more accurately reflect the costs of providing this valuable service which has helped so many in the COPD community to improve their quality of life and reduce hospitalizations. The increased payment is a significant step to ensure that these programs will be sustained over time.

Proposed Payment Changes to Certain Off-Campus Outpatient Departments

We are supportive of the position taken by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) and the National Association for the Medical Director of Respiratory Care (NAMDRC) with respect to CMS' proposed changes that impact payment to certain off-campus outpatient departments. Although their comments focus on issues related to both cardiac rehabilitation and pulmonary rehabilitation, the AARC is particularly interested in pulmonary rehabilitation services and the impact this program has on some of the most vulnerable respiratory patients who suffer from moderate, severe or very severe COPD. Therefore, our comments reiterate the concerns of the other organizations with respect to that particular program.

We take strong issue with the proposed rule's implementation of Section 603 pf P.L. 114-74. The notice explicitly states that **"these proposals are made in accordance with our belief that section 603… is intended to curb the practice of hospital acquisition of physician practices that result in receiving additional Medicare payment for similar services."** Inclusion of pulmonary rehabilitation services along with cardiac rehabilitation, per Table 21 in the proposed regulation, is not only contrary to simple facts but is illogical as well.

The basic premise of Section 603 and the proposed rule is to halt the purchase of physician practices that result in higher payment to hospitals that, after acquisition, provide the same/similar services that had been provided in the physician office. Before making final decisions, CMS should be aware of the following facts:

Capital Investment

The capital investment in equipment and ongoing expense of staff preclude physician offices from offering pulmonary rehabilitation services. Multiple treadmills, monitoring equipment and physical space requirements do not fit into any traditional physician office model, literally and figuratively.

We believe the physical space requirements alone that are needed to make pulmonary rehabilitation cost effective serve as a genuine barrier to the provision of these services in a physician office setting. Coupled with the payment amounts for these services in the physician office setting (e.g., approximately $30.00 per 1 hour session), there is simply no economy of scale to warrant provision of these services in the physician office setting in the first place. Actual numbers of providers billing Medicare for these services support the argument of a very small number of actual providers with a declining number of billed services:

	Number of Providers			**Number of Services**		
	2012	**2013**	**2014**	**2012**	**2013**	**2014**
G0424	207	236	231	29,871	25,564	22,603

Source: Medicare fee-for-service Provider Utilization & Payment Data Public Use File

The reduction in the number of services billed through the physician fee schedule for pulmonary rehabilitation has dropped dramatically over the past three years (i.e., 24% reduction). Coupling the low number of providers with the actual number of services, in our view, unquestionably signals that the business model of provision of these services through the physician office setting are barely miniscule compared to the hospital setting and have been so for years.

There is NO evidence that the extremely limited number of physician practices that bill for pulmonary rehabilitation services are actually selling their entire practice, or a portion of it devoted to pulmonary rehabilitation. A simple comparison of actual Medicare outlays through the physician office setting (under the physician fee schedule) and the hospital outpatient setting (under the hospital outpatient prospective payment system) clearly indicates that, because of the capital requirements addressed above, historically the location for these services has been, for years, the hospital setting.

Pulmonary Rehabilitation Services (G0424)

Medicare Payments for HCPCS code G0424 through the physician fee schedule

	2012	**2013**	**2014**
TOTAL PAYMENTS	$688,489.27	$589,116.95	$535,512.81
Pulmonary Disease Specialty	$340,805.64	$310,065.29	$229,832.58

(Source: Physician Supplier Procedure Summary File)

G0424 total allowed charges though hospital outpatient prospective payment

Year	Total Allowed Charges	Unique # of Providers
2012	$108,515,429	1,260
2013	$115,238,410	1,320
2014	$119,809,898	1,350

(Source: 100% Outpatient SAF)

These data strongly indicate that G0424 pulmonary practice physician office billing for the most recent year data are available ($230K) compared to hospital outpatient allowed charges ($119M) is significantly **less than one tenth of 1 percent** of billing through the hospital setting. To argue that hospitals are purchasing pulmonary practices for financial gain tied to pulmonary rehab services defies Medicare data as well as financial logic. If the CMS premise was valid, one would expect the aggregate physician office billing to be much greater than $535K.

Given the premise of the proposed regulation to stem the tide of hospital acquisition of physician practices, when we examined Medicare data of physician specialties billing G0424, we are concerned that although the "non-pulmonary disease" specialties account for only $305K, those billings do represent more than 50% of the total Medicare payments for the service. We cannot help but be puzzled that such billings are likely erroneous, either through error or other inappropriate billing practices.

Also, we strongly question the appropriateness of the physician office billings that have been identified. Given the fact that the ***Clinical Practice Guidelines*** for these services delineate all of the physical and staffing requirements for such programs, it makes no financial sense for a physician office to provide these services BECAUSE the physician fee schedule payment is so low in comparison to the hospital setting where "economy of scale" is integral to the successful management of such programs.

RECOMMENDATION

We recommend that pulmonary rehabilitation services (HCPCS G0424) warrant exemption from rules that would alter the current ability of hospitals to bill Medicare for these services through the hospital outpatient prospective payment system.

Conclusion

The unintended consequences of this proposal are questionable. The Agency has cited the very low referral rates for these services compared to medical need. If this rule is enacted as proposed, hospitals that wish to expand their programs to meet increased referrals, invariably at off-campus locations, will be precluded from doing so because of payment reductions based on flawed logic and data to the contrary. Likewise, hospitals that are moving toward

establishment of these programs MUST find space within 250 yards of the main campus to make the programs viable, an option that will undoubtedly preclude such programs from opening.

We appreciate the opportunity to comment on these proposed rules and hope that CMS will take seriously exempting pulmonary rehabilitation programs from the proposed payment changes for off-campus outpatient departments. We believe the data and facts presented above provide a clear picture that hospitals are clearly not purchasing physician practices with respect to these programs for the purpose of receiving a higher payment.

Sincerely,

Frank R. Salvatore, RRT, MBA, FAARC
President