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September 28, 2020

Administrator Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1736-P – Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, etc.

As President of the American Association for Respiratory Care (AARC), I am pleased to submit comments regarding proposed updates to the Hospital Outpatient Prospective Payment System (HOPPS) for Calendar Year (CY) 2021. The AARC is a national professional organization with membership of over 45,000 respiratory therapists and whose organizational activities impact over 150,000 practicing respiratory therapists across the country. Respiratory therapists specialize in providing pulmonary diagnostics and care and are experts in treating patients who suffer from respiratory conditions like Chronic Obstructive Pulmonary Disease (COPD), asthma, pneumonia, lung trauma and other respiratory-related diagnoses.

X. Proposed Nonrecurring Policy Changes/A.2. Proposal to Allow Direct Supervision of Pulmonary Rehabilitation Services, Cardiac Rehabilitation Services and Intensive Cardiac Rehabilitation Services Using Interactive Telecommunications Technology

Medicare beneficiaries with Chronic Obstructive Pulmonary Disease (COPD) are not only fragile absent a pandemic, they face substantial increased risk of serious complications and even death if exposed to COVID-19 during the public health emergency (PHE). Cardiac and pulmonary rehabilitation programs are life-changing experiences and have faced significant challenges during the PHE with many closing their programs to keep patients safe, resulting in the inability of beneficiaries enrolled in these programs to find any type of support to continue their ongoing sessions.

We commend CMS for recognizing that direct physician supervision of cardiac and pulmonary rehabilitation services mandated by the statute that also requires the physician to be "immediately available" could pose a problem during the PHE. We applaud and support the decision by CMS to establish a policy in the March 31 interim final rule that the supervising physician could meet the "direct" supervision requirement virtually for the duration of the PHE

with their presence via audio-visual real-time communications technology when use of such technology "is indicated to **reduce exposure risks for the beneficiary or health care provider."**

In its CY 2021 HOPPS update, CMS is now proposing to make this policy permanent effective January 1, 2021, subject to the clinical judgment of the supervising physician which allows for continued patient access while at the same time reducing the burden for providers at the end of the PHE. We strongly support the proposed change and appreciate CMS establishing a policy that allows physicians to meet the intent of the law and that does not compromise the safety of the beneficiary or the provider. However, the following statements in the discussion of virtual supervision related to cardiac and pulmonary rehabilitation at 85 FR 48936 are concerning.

> For example, use of real-time audio and video telecommunications technology could allow a supervising physician to observe the patient during treatment as they interact with or respond to the in-person clinical staff (emphasis added). Thus, the supervising physician's immediate availability to furnish assistance and direction during the service could be met virtually without requiring the physician's physical presence in that location (emphasis added).

It is unclear from these statements whether CMS is saying cardiac and pulmonary rehabilitation are in-person services or whether the example is meant to be interpreted in general terms in describing the value of virtual direct supervision.

In its May 8, 2020 Interim Final Rule (IFC), CMS established several scenarios in which outpatient services could be furnished in temporary expansion locations of a hospital or community health center (including the patient's home). We interpret CMS' rules to include cardiac and pulmonary rehabilitation services as outpatient therapy, education, and training that can be furnished "other than in-person" in temporary expansion sites, including a patient's home, if criteria to designate the sites as a provider-based department of the hospital are met. We also believe these services include pulmonary rehabilitation for those beneficiaries who do not meet the COPD criteria that CMS considers to be individual respiratory therapy services, e.g., G0237, G0238, and G0239.

We expect these services to be furnished by clinical staff via telecommunications technology and billed under the HOPPS because there is no professional service that is separately billed under the physician fee schedule. While we recognize CMS has provided an in-depth discussion and clarification of the rules applicable to furnishing outpatient services in temporary expansion locations during the PHE, the reference to "in person" services in the proposed CY 2021 HOPPS update as an example of the physician's virtual supervision in the same paragraph with discussion of cardiac and pulmonary rehabilitation has caused us to question whether this interpretation is correct. We believe the example is confusing and misleading and requires further clarification so as not to be misinterpreted.

Respiratory therapists are key clinical staff among the multi-disciplinary team furnishing pulmonary rehabilitation services in the hospital outpatient setting, and we want to make sure they and the patients they serve are protected. It is essential that Medicare beneficiaries who rely on these valuable programs have continued access in order to maintain their health and lessen the chance of an acute exacerbation that may cause them to be admitted to the hospital

and put them in harm's way of contracting COVID-19. Because of these concerns, we assume the multi-disciplinary clinical staff providing cardiac and pulmonary rehabilitation services would not be in the beneficiary's home to eliminate health risks and to keep the patient safe, thus, rendering the services through telecommunications technology.

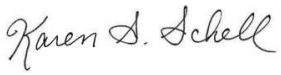
We want to make sure we provide our members with accurate and concise information to alleviate any hospital compliance issues or confusion that may arise due to misinformation and offer the following recommendation:

Recommendation:

CMS should make a definitive statement in the final rule specific to outpatient cardiac and pulmonary rehabilitation services to clarify that clinical staff can furnish the services using real-time audio-visual two-way communications technology to Medicare beneficiaries in their homes with the staff at the hospital outpatient provider-based location and the physician providing direct supervision through a virtual presence.

We commend CMS on the many flexibilities it has implemented during this challenging time to reduce barriers so Medicare beneficiaries can receive the care they need and appreciate the opportunity to provide comments on the CY 2021 HOPPS update.

Sincerely,



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