January 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Administrator Brooks-LaSure:

The above professional organizations would like to express our concern over Calendar Year (CY) 2022 CMS regulations that have presented a *contradiction in care delivery for cardiac and pulmonary rehabilitation.* This inconsistency, if not corrected, will lead to the loss of services that have been critical to Medicare beneficiaries during the pandemic and have immense potential beyond the current situation.

The two settings that CMS allows for delivery of these services are the physician office and the hospital outpatient setting. Over the past 25 years, delivery of cardiac and pulmonary rehabilitation has shifted to being provided predominantly in the hospital outpatient setting with the physician office no longer a viable option for most practices, due to space, staff, and financial restrictions (i.e., very low reimbursement). Less than 2 percent of cardiac and pulmonary rehabilitation services are provided in physician offices. Over 98 percent of these services are under hospital outpatient services.

The final CY 2022 Physician Fee Schedule (PFS) allows cardiac and pulmonary rehabilitation to continue delivery via telehealth through CY 2023 by placing the relevant codes on CMS' list of covered telehealth services as Category 3 codes with the stated purpose of collecting additional evidence as to the clinical benefit of *virtual delivery* in this setting. However, the final CY 2022 Hospital Outpatient Prospective Payment System (HOPPS) update which covers virtual delivery of these services via communications technology under CMS' *Hospitals without Walls* waivers will end when the public health emergency (PHE) expires.

The dichotomy is that the virtual delivery for the majority of Medicare beneficiaries who participate in these programs **will cease to be available** with the cessation of the PHE, and the ability to produce additional evidence of the clinical benefits of virtual delivery in this setting will be lost. With most outpatient departments shut down and staff redeployed to acute care during the pandemic, this temporary waiver allows these patients to continue receiving cardiac and pulmonary rehabilitation in their home or other setting outside the hospital. With this option, rehabilitation staff could stay in contact with patients, observe exercise with real-time audio-visual technology, and meet educational needs. Early studies conducted under these COVID circumstances have demonstrated evidence of safety and similar training intensities[1] and comparable referral rates, patient acceptance, and adherence.[2]

The cessation of virtual hospital outpatient pulmonary rehabilitation with expiration of the PHE is of urgent concern because, effective January 1, 2022, CMS expanded coverage of pulmonary rehabilitation for individuals who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least 4 weeks. If virtual delivery of pulmonary rehabilitation is no longer available after the PHE, important data will be lost in determining the effectiveness of virtual treatment options for these beneficiaries who would benefit from receiving virtual pulmonary rehabilitation.

We recently highlighted this inconsistency in coverage to the Division of Practitioner Services in the Ambulatory and Hospital Policy Group and to those who work on hospital outpatient payment policy with no response to date, other than, "We are reviewing our rule for consistency." We are perplexed that the PFS reflects the belief that cardiac and pulmonary rehabilitation services are important enough to extend a virtual delivery option through CY 2023 while the HOPPS plans to terminate essentially all virtual delivery of cardiac and pulmonary rehabilitation at some different point in the coming future.

We understand that the PHE status has allowed current temporary waivers to be in place. The utilization of virtual delivery of services for many patient-care services has provided an avenue for expansion of delivery with positive outcomes, such as improved patient adherence, earlier intervention, removal of system and patient barriers like distance, transportation, delay of services due to limited capacity, and, importantly, patient preference.

Cardiac and pulmonary rehabilitation programs are an important part of recovery for those with chronic heart and lung disease and who deal with acute events and exacerbations of their conditions. After hospitalization, it is the standard of care to provide outpatient cardiac or pulmonary rehabilitation services, consisting of exercise and education. Strong, substantiated evidence[3,4,5] demonstrates reduced re-hospitalization and all-cause mortality, as well as improving quality of life and lifestyle choices so patients may better self-manage these chronic diseases.

Based on the need for these important programs and evidence of demonstrated improved outcomes, we recommend that a virtual delivery option for cardiac and pulmonary rehabilitation be continued in the hospital outpatient setting through calendar year 2022 and preferably through 2023 in order to provide further opportunity to assess the value of these services. Medicare beneficiaries deserve to receive these high value rehabilitation treatments. Please contact Karen Lui at karen@advocate4action.com if any additional information would be helpful.

Sincerely,

American Association of Cardiovascular and Pulmonary Rehabilitation
American Association for Respiratory Care
American College of Cardiology
American College of Chest Physicians
American Heart Association
American Thoracic Society

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1. Keteyian SJ, Grimshaw C, Clinton A, et al. A comparison of exercise intensity in hybrid versus standard phase two cardiac rehabilitation. JCRP. 2021;41:19-22.
2. Ricci JA, Williams T, Akbarali RA., et al. Health care system design and virtual delivery system: cardiovascular rehabilitation access and participation rates during Covid 19 public health emergency. AHA Scientific Sessions 2020 P2365, November 13, 2020.
3. Lindenauer PK, Stefan MS, Pekow PS, et al. Association between initiation of pulmonary rehabilitation after hospitalization for COPD and 1-year survival among Medicare beneficiaries. JAMA. 2020;323(18):1813-1823.
4. Anderson L. et al. Exercise-based cardiac rehabilitation for coronary heart disease. Cochrane Database Syst Rev, 2016(1): p. CD001800.
5. Dunlay SM, et al. Participation in cardiac rehabilitation, readmissions, and death after acute myocardial infarction. Am J Med, 2014:127(6): p. 538-46.