American Association of Cardiovascular and Pulmonary Rehabilitation

Legislative Priorities –2023

HR 955-SOS: Sustaining Outpatient Services Act

Background: Medicare payment methodologies differ dependent on site of service. This is due to the actual payment methodology used by Medicare to determine payment amounts. For example, when Medicare computes payment for services reimbursed in a physician office, three variables are computed: the relative value of the service (RVU), the practice expense associated with the specific service, and the malpractice expense associated with the specific service.

When Medicare computes payment **for the same service** provided in a hospital outpatient setting, the agency uses charge data reported on every claim submitted to Medicare as well as hospital cost report data, also submitted by the hospital. Therefore, it is not unusual for the same service to receive different payment amounts based on the **"site of service."**

Both Congress and CMS recognized that this was creating strong incentives to game the payment system. To address this problem, Section 603 of the 2015 Budget Act mandated that hospitals at these identified locations would no longer be reimbursed under the hospital outpatient methodology. Instead, Section 603 implemented the following:

1. If an existing off campus (beyond 250 yards) service moves to a new location, the hospital is reimbursed at a "physician fee schedule-equivalent" rate rather than the hospital outpatient rate.
2. If a hospital opens a NEW hospital outpatient service, that new service must be within 250 yards of the main campus in order to receive hospital outpatient reimbursement; otherwise, the physician fee schedule-equivalent rate applies.

The **primary premise of Section 603 does not apply to either PR or CR** because hospitals are not purchasing pulmonary or cardiac practices to benefit from the higher reimbursement rate for PR/CR services. **Simply stated, these services are NOT being performed in physician offices,** nor have they been provided in that setting for years.

Impact on Pulmonary/Cardiac Rehabilitation (PR/CR): Hospitals that choose to expand or relocate (beyond the 250-yard threshold) services creates a very strong disincentive for hospitals to improve access to PR/CR services. (A very limited number of exceptions to this exist.)

CMS recognized this reality as an "unintended consequence" of Section 603, but the Agency has no authority to address our problem. We were left to seek a legislative correction (a "Medicare fix").

Solution: Legislation could exempt certain hospital outpatient services from Section 603 by *implementing regulations that create specific financial thresholds*. As long as no physician specialty, nationwide, bills for <u>any CPT or HCPCS code</u> under the Medicare Physician Fee Schedule in an aggregate

amount greater than $2 million in the previous year for which data are available, that code (or codes) would be exempt from Section 603 requirements.

Because billing for 93798 and G0424 (CPT 94625/26 effective 1-1-2022) under the physician fee schedule has no physician specialty billing exceeding $2M, those codes would be exempt from Section 603 requirements.

IN SUMMARY

Cardiac and pulmonary rehabilitation services have been unable to expand patient access to meet demand for these beneficial services due to Section 603, compounded by PHE program closures. The Sustaining Outpatient Services (SOS) Act is highly supported by all the professional cardiac and pulmonary organizations without opposition. It is the **solution** programs and patients need now.

HR 1406-Sustainable Cardiopulmonary Rehabilitation Services in the Home Act

Virtual Delivery of Cardiac and Pulmonary Rehabilitation in the Hospital Outpatient Setting

During the pandemic, hospitals were allowed to provide some outpatient services through virtual means to Medicare beneficiaries in the home (real-time, audio-visual communications technology). Hospital-based cardiac and pulmonary rehabilitation programs were included in the emergency waivers. This proved to be very beneficial with some services shut down and staff re-deployed through the public health emergency (PHE). With the expiration of the PHE on May 11, 2023, virtual delivery of these services in the hospital setting also ceases to be an option. The patient benefits and need for continuation of virtual services such as cardiac and pulmonary rehabilitation that hospitals provide has been recognized by patients, providers, and Congress. Congress needs to pass a law that allows continuation of a virtual delivery model of cardiac and pulmonary rehabilitation sessions beyond the PHE.

Only physician offices have been allowed to provide virtual (real-time, audio-visual "telehealth" sessions) cardiac and pulmonary rehabilitation through the year 2024 as a result of passage of the Consolidated Appropriations Act of 2023 that included some temporary telehealth services, including cardiac and pulmonary rehabilitation. (CMS has stated in numerous documents that hospitals do <u>not</u> provide telehealth.)

This bill will:

- Allow delivery of cardiopulmonary rehabilitation services via virtual (real-time, audio-video) telecommunications technology in the beneficiary's home, designating that home as a provider-based location of a hospital outpatient department,
- Allow virtual direct supervision of physician, physician assistant, nurse practitioner, or clinical nurse specialist, through two-way audio-visual communications technology,
- Provide reimbursement for services delivered by a physician or a practitioner, or by a hospital,
- These flexibilities will be extended permanently.

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