Comments – **CMS-1656-P**

The National Association for Medical Direction of Respiratory Care (NAMDRC) is pleased to submit comments on the proposed rule on **Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program.** Proposed Rule published in the ***Federal Register*** on July 14, 2016.

We have worked with other pulmonary societies and it is likely our sister organizations are submitting similar comments related to this proposed rule.

Pulmonary Rehabilitation Payment

Pulmonary rehabilitation (PR) became a covered service by CMS in 2010. For two years, CMS relied on proxy data because no data existed for newly established HCPCS code G0424. In 2012, payment was drastically reduced, based on claims submitted by institutions that did not account for all services to provide this new comprehensive service. From the proposed 2017 payment rate, we presume that institutions have adjusted claims to more accurately reflect the true charges for the broad scope of services to provide this bundled service. This is a significant step in the sustainability of a service that has been demonstrated to be beneficial to the COPD patient population in reduced hospitalization and improved health-related quality of life.

Proposed Payment Changes to Certain Off-Campus Outpatient Departments

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, 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. Here are some key facts regarding pulmonary rehabilitation services:

- The capital investment in equipment and ongoing expense of staff preclude physician offices from offering these services. Multiple treadmills, monitoring equipment and physical space requirements do not fit into any traditional physician office model, literally and figuratively. In our view, 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 (HCPCS code G0424) in the physician office setting, 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 our 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

- For this code, the reduction in number of services billed through the physician fee schedule have dropped dramatically over the past three years: G0424 (24% reduction); coupling the low number of providers with the actual number of services, in our view, unquestionably signal 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 actually bill for these services are actually selling their entire practice, or a portion of it devoted to pulmonary rehabilitation services. A simple comparison of actual Medicare outlays for these services 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 in #1, above, historically the location for these services has been, for years, the hospital setting.

Pulmonary Rehab 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
Pulm 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, currently set at about $30. 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 by our belief that such billings are likely erroneous, either through error or other inappropriate billing practices.

Specialty	2012	2013	2014
TOTAL	$688,489	$589,116	$535,512
Pulmonary Disease	$340,805	$310,065	$229,832
Family Practice	$175,788	$116,681	$183,499
Internal Medicine	$79,053	$78,211	$52,943
Crit Care (intensivists)	$29,964	$29,139	$18,723

Source: Physician Supplier Procedure Summary File 2012-2014

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 understandably and appropriately integral to the successful management of such programs.

One must also question the unintended consequences of this proposal. The Agency has cited the very low referral rates for these services compared to medical need. If this proposed 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.

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.