



March 2, 2018

NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties; Issued February 1, 2018

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter

The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) appreciates the opportunity to comment on the CY 2019 Draft Call Letter. We would like to specifically address pages 179-180 that solicit comments on cost sharing limits.

Cardiac and pulmonary rehabilitation (CR and PR) are evidence-based services provided as part of comprehensive treatment for identified cardiovascular and respiratory diagnoses. Both secondary prevention services include education and exercise, strengthening and rehabilitation. A primary goal is long-term self-management for conditions that include chronic obstructive pulmonary disease (COPD), acute myocardial infarction, systolic heart failure, coronary artery bypass grafting, heart valve surgery, stable angina, and percutaneous coronary interventions (PCI).

These services are effective because both address lifestyle choices and are repetitive, typically delivered over a three month period of time. Reinforcement with a focus on self-efficacy contributes to meaningful outcomes. In one study of Medicare beneficiaries, a strong dose–response relationship was demonstrated between the number of cardiac rehabilitation sessions attended and long-term outcomes. Attending all 36 sessions, the maximum number currently reimbursed by Medicare, was associated with lower risks of death and myocardial infarction at four years compared with attending fewer sessions.¹ Pulmonary rehabilitation initiated shortly after a hospitalization for a COPD exacerbation is clinically effective, safe, and associated with a reduction in subsequent hospital admissions.²

Despite these meaningful outcomes, CR and PR remain underutilized. Current participation rates for CR in the U.S. generally range only from 20% to 30%.^{3,4} It has been estimated that increasing CR participation to 70% would save 25,000 lives and prevent 180,000 hospitalizations annually in the U.S.⁵ The CMS Million Hearts Cardiac Rehabilitation Collaborative (CRC) has set a goal of achieving more than 70% participation in cardiac rehabilitation (CR)/secondary prevention programs by the year 2022. This is in line with Million Hearts' focus since 2012 to prevent 1 million cardiovascular events over 5 years through achieving more than 70% performance in the "ABCS" of aspirin for those at risk, blood pressure control, cholesterol management, and smoking cessation.

Increased cost-sharing burdens for Medicare beneficiaries and particularly multiple co-payments for repetitive services such as CR and PR are contributing factors in these observed low participation rates.

Financial incentives to participate in low-cost services that achieve outcomes valued by CMS should be sought.

Some strategies for consideration:

- A fixed low cost for co-payment (to match original Medicare if possible)
- A co-payment that is lower for first 12 sessions and increases for sessions 13-36
- A co-payment that is tapered as a beneficiary progresses toward program completion
- One “bundled” co-payment (at a reduced cost) up front for a “course” of 36 sessions
- A “rebate” upon completion of 36 sessions
 - Perhaps part of the “average rebate” received by plans to provide additional benefits
- Waiver of co pay for all subsequent sessions after completion of 12 sessions
- Waiver of co pay for CR/PR

AACVPR looks forward to discussing these and other strategies to encourage utilization of pulmonary and cardiac rehabilitation. This is aligned with CMS efforts toward value-based care and care coordination. It would remove the current financial barrier faced by beneficiaries in MAOs and support the CMS Million Hearts Cardiac Rehabilitation Collaborative (CRC) goal of increasing cardiac rehabilitation participation rates to 70% by 2022. It would promote the benefits gained for COPD beneficiaries, the third leading disease in this country and growing.

Respectfully submitted,



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1. Relationship between Cardiac Rehabilitation and Long-Term Risks of Death and Myocardial Infarction Among Elderly Medicare Beneficiaries. Hammill BG, Curtis LH, Schulman KA, Whellan DJ. *Circulation*. 2010;121:63-70.
2. An Official American Thoracic Society/European Respiratory Society Statement: Key Concepts and Advances in Pulmonary Rehabilitation. Spruit MA, Singh SJ, Garvey C, et al. On behalf of the ATS/ERS Task Force on Pulmonary Rehabilitation. *Am J Respir Crit Care Med* Vol 188, Iss. 8, pp e13–e64, Oct 15, 2013.
3. Suaya JA, Shepard DS, Normand SL, Ades PA, Prottas J, Stason WB. Use of cardiac rehabilitation by Medicare beneficiaries after myocardial infarction or coronary bypass surgery. *Circulation*. 2007;116(15):1653-1662.
4. Centers for Disease Control and Prevention (CDC). Receipt of outpatient cardiac rehabilitation among heart attack survivors-United States, 2005. *MMWR Morb Mortal Wkly Rep*. 2008; 57(4):89-94.
5. Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map from the Million Hearts Cardiac Rehabilitation Collaborative. Ades PA, Keteyian SJ, Wright JS, et al. *Journal of the Mayo Clinical Proceedings*, February 2017;92(2):234-242.