December 6, 2024

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

RE: Support for Maintaining Virtual Cardiac and Pulmonary Rehabilitation in any Telehealth Legislation

Dear Speaker Johnson, Majority Leader Schumer, Minority Leader Jeffries, and Minority Leader McConnell:

We write to express our strong support for **Section 105, Codifying In-Home Cardiopulmonary Rehabilitation Flexibilities** of the *Telehealth Modernization Act* (H.R. 7623**)**, and request that Congress advance this virtual cardiac and pulmonary rehabilitation provision as part of any telehealth package before the end of the year. As you may know, this legislation was favorably reported by the House Energy and Commerce Committee on September 18 with a vote of 41-0.

Section 105 (attached) is based on bipartisan legislation to restore and protect access to virtual cardiac and pulmonary rehabilitation for hundreds of thousands of Medicare beneficiaries across the country – the *Sustainable Cardiopulmonary Rehabilitation Services in the Home Act* (H.R. 1406/S. 3021).

The legislation was introduced in the House by Representatives by Reps. John Joyce and Scott Peters, and in the Senate by Sens. Kyrsten Sinema, Marsha Blackburn, and Amy Klobuchar. The *Sustainable Cardiopulmonary Rehabilitation Services in the Home Act* seeks to restore the provisions relating to virtual cardiac and pulmonary rehabilitation that were in place under the COVID-19 public health emergency (PHE). Specifically, this legislation would reauthorize the hospital-based virtual rehabilitation programs that served 95 percent of patients prior to the end of the PHE.

When the PHE expired on May 11, 2023, virtual delivery of cardiopulmonary rehabilitation in the hospital setting also ceased to be an option. While the *Consolidated Appropriations Act, 2023* preserved telehealth access for these services through December 31, 2024, this extension applies only to services delivered in physician office-

based programs, which account for less than five percent of total cardiopulmonary rehabilitation care. Hospital-based programs – where 95 percent of cardiopulmonary services are delivered – remain unable to offer virtual options, creating significant barriers to patient access. The *Telehealth Modernization Act* would address this gap by extending such flexibilities to both physician offices and hospital-based programs.

Cardiac and pulmonary rehabilitation are proven interventions that keep patients alive longer and out of the hospital, and as a result of the PHE, we also know that virtual forms of these programs are an effective way to increase access for patients across the country. On behalf of the hundreds of thousands of Medicare patients who would immediately benefit — and the millions more who will likely need it in the future, we thank you for your leadership and urge you to advance this legislation to restore and protect access to virtual cardiac and pulmonary rehabilitation.

Sincerely,

American Association of Cardiovascular and Pulmonary Rehabilitation
Allergy and Asthma Network
Alliance for Patient Access
American Association for Respiratory Care
American College of Chest Physicians
American Heart Association
American Thoracic Society
Center for Patient Advocacy Leaders
COPD Action Alliance
COPD Foundation
Dorney-Koppel Foundation
Emphysema Foundation of America
Heart Failure Society of America
Patients Rising
Pulmonary Fibrosis Foundation
Right 2 Breathe
Society for Vascular Medicine
Society of Cardiovascular Computed Tomography
The Waiting Room Entertainment

cc: House Committee on Ways and Means
House Committee on Energy and Commerce
Senate Committee on Finance

H.R. 7623, *Telehealth Modernization Act of 2024*

As favorably reported from the House Energy and Commerce Committee
September 18, 2024

SEC. 105. CODIFYING IN-HOME CARDIOPULMONARY REHABILITATION FLEXIBILITIES ESTABLISHED IN RESPONSE TO COVID–19.

Section 1861(eee)(2) of the Social Security Act (42 U.S.C. 1395x(eee)(2)) is amended—

(1) in subparagraph (A)(ii), by inserting ''(including, with respect to items and services furnished through audio-visual real-time communications technology on or after January 1, 2025, and before January 1, 2027, in the home of an individual who is an outpatient of the hospital)'' after ''outpatient basis''; and

(2) in subparagraph (B), by inserting ''(including, with respect to items and services furnished through audio-visual real-time communications technology on or after January 1, 2025, and before January 1, 2027, the virtual presence of such physician, physician assistant, nurse practitioner, or clinical nurse specialist)'' after ''under the program''.

BACKGROUND - CARDIOPULMONARY REHABILITATION

Nearly half of Americans have some form of cardiovascular disease. After a heart attack or heart surgery, completing cardiac rehabilitation can increase life expectancy by up to five years and has been shown to significantly reduce rehospitalizations. However, only one in four Medicare patients even start cardiac rehabilitation, and 90 percent of people don't end up completing their in-person rehabilitation programs, in part because they have traditionally required patients to commute to a hospital or doctor's office 36 times over a three-month period.

Chronic obstructive pulmonary disease, or COPD, affects millions of Americans and is one of the leading causes of death, with higher rates in rural areas (8%) than in urban areas (5%), contributing to the access gap in pulmonary rehabilitation. In addition to COPD, pulmonary rehabilitation is approved for individuals experiencing prolonged respiratory symptoms due to COVID-19. By reducing hospitalizations and improving patient quality of life, pulmonary rehabilitation is an essential component of care for these populations.

During the public health emergency, virtual cardiac and pulmonary rehabilitation became broadly available. The *Hospital Without Walls* waiver allowed rehabilitation departments operated by hospitals to deploy virtual programs, in which patients were supervised in real-time by providers using video communications on computers or mobile devices.

Data has shown that virtual cardiac rehabilitation is effective, reducing death rates by 36 percent as compared to patients who did not complete their program. Virtual cardiac rehab patients experience lower readmission rates. Pulmonary virtual programs have also demonstrated better access and similar outcomes to facility programs.

The availability of virtual cardiac and pulmonary rehabilitation was a significant step forward in eliminating barriers that have prevented patients from starting or completing traditional rehab programs. Many Medicare beneficiaries live in "rehabilitation deserts" — rural, suburban, and even

urban communities in which in-person rehab facilities are either too few or too far away. For patients with mobility challenges, jobs with limited time off, or who depend upon public transportation, traveling twice a week for three months is not a viable option. Studies have found that women and members of minority groups are less likely to complete cardiac or pulmonary rehabilitation. In situations where patients have language or cultural barriers that make it difficult to participate in a program at a nearby facility, virtual rehabilitation allows them to work with appropriate providers anywhere in the country.

Expanding access lowers healthcare spending. According to data released by the Department of Health and Human Services' Million Hearts initiative, when patients complete all 36 sessions of cardiac rehabilitation, it saves between $4,950 and $9,200 per person per year of life saved.