Homecare Congress Must Stop Drastic Cuts to DME Items in Rural & Non-Bid Areas—Support HR 4229

Background

110 of the largest, most densely populated MSAs in the country currently participate as Competitively Bid Areas (CBAs) in the Competitive Bidding Program (CBP) for DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies). These CBAs are home to 58% of all Medicare beneficiaries in the nation.

Under the CBP, durable medical equipment (DME) suppliers, often called home medical equipment (HME) suppliers, compete for a limited number of contracts to serve Medicare beneficiaries residing in these CBAs through an auction program that awards contracts to those with the lowest bid amounts, resulting in a drastic reduction in competition for suppliers and opportunity to increase market share.

On October 31st, 2014, the Centers for Medicare & Medicaid Services (CMS) released the final rule *on "Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies",* which established the methodology for making national price adjustments to the fee-for-service payments of specified HME, enteral nutrition, and related services paid under fee schedules.

On January 1, 2016, CMS began the first phase of a two-part reimbursement adjustment that applies pricing derived from these highly populated CBAs to all areas of the country without exception for rural America. Bid areas like Atlanta and Los Angeles set prices for rural and non-urban areas in spite of non-bid areas not having the opportunity to submit pricing to account for unique costs of accessing and caring for beneficiaries in these areas. On July 1, 2016, the prices were fully phased in, slashing Medicare reimbursement by over 50% on average. Congress intervened out of concern in December 2016, statutorily extending the reimbursement rates in effect on January 1, 2016 to December 31, 2016 via the 21st Century CURES legislation. On January 1, 2017, the full cut took effect once more. CMS also provided limited regulatory relief to rural and non-contiguous areas through its May 2018 Interim Final Rule and November 2018 ESRD/DMEPOS Final Rule out of concern for access issues. However, both regulations fell short of providing critically needed relief across all non-bid areas.

How CMS Implemented Pricing Nationwide

For qualified HME items, the final rule phased in a new reimbursement rate for non-CBAs over 6 months that began January 1, 2016. CMS divided up the contiguous 48 states into eight distinct regions. An unweighted average of all of the Single Price Amounts (SPAs) from high population CBAs within each region were used to determine the Regional Single Price Amount (RSPA) for each affected product.

Claims with dates of service from January 1, 2016 through June 30, 2016 were based on 50 percent of the un-adjusted fee schedule amount and 50 percent of the RSPA adjusted fee schedule from Round Two bid area prices. On July 1, 2016, reimbursement rates became 100% of the RSPA adjusted fee schedule amount based on pricing from new Round Two ReCompete bid area prices effective July 1. The following are examples of these drastic cuts –

HCPCS Code	Region	12/31/15	1/1/16 Rate	1/1/17 Rate
E0143 (walker with wheels)	SouthEast	$18.59	$11.01 **(-41%)**	$4.76 **(-74%)**
K0003 (standard wheelchair)	MidEast	$92.19	$65.46 **(-29%)**	$31.16 **(-66%)**
E1390 (O2 concentrator)	Far West	$180.92	$135.65 **(-25%)**	$66.53 **(-63%)**
E2402 (NPWT Pump)	Great Lakes	$1,642.09	$1,221.13 **(-26%)**	$641.99 **(-61%)**
E0601 (CPAP)	Rocky Mountain	$101.03	$73.33 **(-27%)**	$39.75 **(-60.7%)**
K0823 (standard PMD)	New England	$577.42	$427.33 **(-26%)**	$256.31**(-56%)**

In May 2017, CMS released a modified fee schedule for the affected claims that was incongruent with Congressional intent. Instead of extending the 1/1/16 blended rate, CMS recalculated the blended rates to be 50% of the original fee schedule and 50% of the newly derived Round Two ReCompete Competitive Bidding rates, resulting in lower payments for most items.

The Risk to Rural America

CMS has acknowledged that claims data does not capture all of the challenges experienced by beneficiaries and suppliers, the trending decline in the number of suppliers nationwide, and the risk of reduced access to DME that puts beneficiaries at risk of poor health outcomes and increased hospital stays.

- **Rural America has unique attributes that have distinct costs that differ from their urban counterparts.** The HME Industry has convincing data that indicates providing DME items in rural areas have higher costs in order to access, care for, and support non-urban and rural beneficiaries, which are *not accounted for* in the RSPAs, such as:
    - Employee time, fuel costs, and mileage to drive to the beneficiary's residence
    - Widely ranging geological and road characteristics that could require specialty vehicles, including 4-wheel drive, ATVs, tractors, snowmobiles, ferry coordination, and more
    - Sparsely populated areas that don't offer the same routing efficiencies as dense urban areas
- **Suppliers in non-CBAs will not have economies of scale to offset the drastic payment cuts.** In CBAs, suppliers try to offset the significant payment cuts through increased volume of beneficiaries while supplementing payments with serving markets outside the CBA. However, under this forthcoming mandate to expand the program nationally, suppliers in non-CBAs will receive the same drastic payment cuts set in CBAs, without exclusive contracts and increase in volume of business or the ability to compensate with higher rates outside of the CBA.
- **Unsustainable reimbursement is stripping communities of resources.** We estimate that over 40% of traditional HME companies have closed or are no longer taking Medicare due to the unsustainable pricing derived from the controversial Medicare auction program since 2013. The drastic loss of suppliers has a crippling effect on beneficiaries' access to critical home medical equipment and services and jeopardizes the homecare infrastructure in which millions rely to safely maintain their independence at home.

Solution

On November 2, 2017, Representatives Cathy McMorris Rodgers (R—WA) and Dave Loebsack (D—IA) introduced HR 4229 "Protecting Home Oxygen & Medical Equipment Access Act" (Protecting HOME Access Act). This legislation will provide more time for Congress to evaluate the effects of bidding-derived pricing for rural and non-CB areas on patient access by extending the transition period from January 1, 2017 to December 31, 2018 with reimbursement rates equal to rates in effect on January 1, 2016. In effect, this rolls back the second round of cuts that went into effect on July 1, 2016.

Our Ask:

AAHomecare strongly urges Members of Congress to co-sponsor HR 4229 to provide relief for homecare patients and suppliers in non-Competitive Bidding areas. Members of Congress should contact Representative Cathy McMorris Rodgers' office to co-sponsor.