



**WRITTEN STATEMENT OF THE
AMERICAN ASSOCIATION FOR HOMECARE**

**SUBMITTED FOR THE
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HEALTH
JULY 28, 2015**

American Association for Homecare
1707 L St NW, Suite 350
Washington, DC 20036
Phone: 202-372-0107
Fax: 202-835-8306

**WRITTEN STATEMENT OF THE
AMERICAN ASSOCIATION FOR HOMECARE**

**SUBMITTED FOR THE
HOUSE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HEALTH
JULY 28, 2015**

The American Association for Homecare (AAHomecare) is pleased to provide its views on the rural health care disparities created by Medicare regulations to the House Ways And Means Subcommittee on Health.

AAHomecare is the national trade association for home medical equipment (HME) providers, manufacturers and other stakeholders in the homecare community. AAHomecare members serve the medical needs of Americans who require home oxygen therapy, mobility assistive technologies (standard and complex wheelchairs), hospital beds, diabetic testing and medical supplies, inhalation drug therapy, home infusion and other home medical products, services and supplies.

Membership reflects a broad cross-section of the homecare community, including providers of all sizes operating approximately 3,000 locations in all 50 states.

AAHomecare strongly recommends that Congress preserve and strengthen access to home medical equipment for the millions of Americans who require medical care in their homes. In particular, we ask that Congress protect access to home medical equipment in rural areas by preventing the use of prices derived from the Medicare competitive bidding program, which has been recognized as flawed by well over 200 economists, computer scientists, statisticians and auction experts from around the world. These rates do not reflect the true cost of business in rural areas, where fewer providers serve larger areas and face higher delivery and associated service and repair costs.

To do so otherwise, would force the closure of many home medical equipment providers in these areas, cost jobs in an economy that cannot afford to lose them, and deprive a growing number of patients, many of whom are seniors or people with disabilities, access to the equipment and services they need to receive medical care in their homes.

Background

Cost Effectiveness of Homecare

HME offers an efficient and cost-effective way to allow patients to receive care they need at home. The need for HME and HME providers will continue to grow to serve the ever-increasing number of older Americans. Homecare represents a small but cost-effective portion of the more than \$2.3 trillion national health expenditures (NHE) in the United States, and approximately 15.5 million Medicare beneficiaries require some type of home medical equipment annually, from bedside commodes for people who have hip replacements to high-tech ventilators for quadriplegics.

Yet, not all products are equal: some require licensed or credentialed clinicians to be on staff or cost \$15,000 just to procure. While past reports from Congress and the Office of Inspector General (OIG) shed light on products they believe to be overpaid, many others are unprofitable for providers to provide even before the bidding program. The high cost of fuel, labor, rent and utilities, and regulatory compliance associated with billing and collections, HIPAA privacy, identity theft, IT security, Sarbanes-Oxley, waste disposal, beneficiary and employee safety, OSHA, DOT and FDA regulations continues to escalate year after year. Anyone who has ever required HME or had a relative who needed it can attest that our service includes much more than just the equipment.

With greater access to quality equipment and services at home, beneficiaries and Medicare will spend less on hospital stays, emergency room visits, and nursing home admissions. Home medical equipment is an important part of the solution to the nation’s healthcare funding crisis. The facts bear this statement out as private health care plans have contracted for our services for decades and reaped the cost-savings along the way. Even the current Administration is trying to develop programs to manage chronically ill Medicare patients in the home through new demonstration projects and the Innovation Center.

One key fact that is sometimes lost in this debate is that HME represents about one percent of annual Medicare spending. So while this program appears to reduce HME expenditures when simply comparing past and current Medicare Part B expenditures, CMS has not examined the cost shifting that occurs as a result of the program as more beneficiaries will be forced to receive care in hospitals, nursing homes, and emergency treatments.

Impact on Rural Areas

The problems with competitive bidding are already well known from the experiences in the original Round 1 and Round 2 areas. Soon, these impacts will be expanded to suppliers and beneficiaries in the small towns and rural areas outside of the original bid areas. These rural home medical equipment providers are in danger of being hit with devastating Medicare cuts that will hurt patient access to HME, close businesses and cost jobs.

On October 31, 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 establishes the methodology for making national price adjustments to payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) paid under fee schedules.

Data used to calculate the fee schedule was based upon information gathered from the DMEPOS competitive bidding programs (CBPs) and phase in special payment rules in a limited number of competitive bidding areas (CBAs) under the CBP for certain, specified DME and enteral nutrition products.

For qualified DME items, the final rule phases in, over 6 months, a new reimbursement rate for non-CBAs. On January 1, 2016, the reimbursement rate for these claims (with dates of service from January 1, 2016 through June 30, 2016) will be based on 50 percent of the un-adjusted fee schedule amount and 50 percent of the adjusted fee schedule amount which will be based on the regional competitive bidding rates.

Starting on July 1, 2016, reimbursement rate will be 100% of the adjusted fee schedule amount which will be based on regional competitive bidding rates. The following are examples of these drastic cuts –

HCPCS Code	Region	Current	1/1/16 rate	7/1/16 rate
E1390 (O2 concentrator)	Mideast	\$178.23	\$134.21 (-25%)	\$90.18 (-49%)
EO470 (BiPAP)	Rocky MT	\$241.85	\$178.50 (-26%)	\$115.14 (-52%)
K0003 (standard wheelchair)	Great Lakes	\$97.98	\$68.78 (-30%)	\$39.58 (-60%)
K0823 (standard PMD)	New England	\$568.89	\$424.22 (-25%)	\$279.55 (-51%)

The application of payment rates, set by CMS’s flawed competitive bidding process, to non-CBAs will disrupt Medicare beneficiaries’ access to the DME items they need. In CBAs, suppliers are forced to accept contracts for

DME items at a lower rate with the knowledge that there will be a limited number of suppliers that can provide service and supplies in that bid area. Suppliers then try to make up for the drastic payment cuts through increased volume of beneficiaries served in that CBA blended with the higher payments from beneficiaries served outside of the CBA. As a result of CMS' final rule, suppliers in non-competitive bid areas 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. The industry also has convincing data that indicates providing DME items in rural areas have a higher cost than in urban areas.

CMS' final rule also limits the bid ceiling for future rounds of competitive bidding to payment rates set by previous rounds of bidding. Currently, bid limits are set by the fee schedule, which allows for adjustments for inflation. CMS has indicated that it plans to continue competitive bidding for DME items far into the future. Decreasing the bid ceiling limit over many years, while medical inflation continues to rise, will set artificially low rates, which will hamper competition. Ever decreasing bid limits will make it impossible to set market prices through an auction process, without negatively impacting beneficiary care. Congress required CMS to save money compared to the (unadjusted) fee schedules, because taken to its logical conclusion, CMS' plan would eventually result in suppliers paying the government to provide items and services.

Conclusion

Rural home medical equipment providers are in danger of being hit with devastating Medicare cuts that will close businesses and cost jobs.

AAHomecare strongly urges the Committee to take action to prevent these drastic cuts and protect access to home medical equipment for seniors and people with disabilities in rural areas.

###

The American Association for Homecare represents providers of home medical or durable medical equipment and services who serve the needs of millions of Americans who require prescribed oxygen therapy, wheelchairs, enteral feeding, and other medical equipment, services, and supplies at home. Visit www.aahomecare.org.