



Via Electronic Mail: Rural_Urban@mail.house.gov

November 27, 2019

Chairman Richard E. Neal and Ranking Member Kevin Brady
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Re: **RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE REQUEST FOR INFORMATION**

Dear Chairman Neal and Ranking Member Brady,

The American Association for Homecare (AAHomecare) is pleased to submit these comments in response to the above captioned Request for Information. AAHomecare is the national association representing the interests of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Our members are proud to be part of the continuum of care that assures that Medicare beneficiaries receive cost effective, medically necessary, safe and reliable home care products and services. The following are our responses to the Ways and Means Committee's questions to 1, 3, 5, 8, 9, and 10.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Rural America has unique attributes that have distinct costs that differ from their urban counterparts. The home medical equipment (HME) Industry has convincing data that demonstrates providing durable medical equipment (DME) items and services in rural areas is more costly. These higher costs to access, care for, and support rural beneficiaries are *not accounted for* in the Medicare Regional Single Payment Amounts (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 do not offer the same routing efficiencies as dense urban areas.

Rates in rural (non-bid) areas were reduced on average 50% starting in 2016. The reduced rates impacted timely access to DME in these rural communities. A Dobson DaVanzo & Associates study of non-bid (rural) areas found that 52% of Medicare beneficiaries experienced difficulties accessing DME and 78% of respondents experienced delays with the discharge process.

Medicare payment rates in rural areas must be set with the understanding that it is more expensive to service beneficiaries in rural areas. Otherwise, the DME supplier infrastructure will deteriorate beyond repair, resulting in DMEPOS access issues for all Americans. We urge Congress to pass H.R. 2771 to provide permanent relief for Rural America.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Exacerbating the underlying problem of low DME reimbursement rates in rural areas is the fact that Medicare applied a budget neutrality “offset” to the 2017 rural fee schedules for stationary oxygen equipment. This “budget neutrality” provision was passed by Congress in the Balanced Budget Act of 1997, years before the competitive bid program (CBP) was enacted in 2003. This outdated policy was never intended to apply to rates derived from the CBP, resulting in even more unsustainable rates in rural communities. Although CMS acknowledges that it is more expensive to provide liquid oxygen than other oxygen modalities and set slightly higher rates for liquid oxygen, the increased cost to provide liquid oxygen services is so significant that very few DME suppliers can afford to provide it. To illustrate the relative additional costs of providing beneficiaries with liquid oxygen systems, it requires four to six deliveries per month to replace liquid oxygen equipment. In comparison, traditional gas equipment can be delivered once a month. Medicare data confirms that from 2012 to 2018, there were 70 percent fewer DME suppliers providing liquid oxygen contents (E0442 and E0444) across the country. Medicare claims data also shows that beneficiary utilization of portable liquid oxygen (E0434) experienced a significant drop at roughly 25% within just one year between CY2016-CY2017. The drop is even greater between CY2015-CY2017 at a 44% decrease. Due to the apparent access issues, we recommend Congress to exempt liquid oxygen from the CBP.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

Beyond the implementation of telehealth/telemedicine, we encourage the Committee to consider the expansion of remote patient monitoring services (RPM) to further enable access and quality of care for rural and underserved communities. Digitally enabled medical devices, including certain DME items, help collapse time and space by capturing snapshots of physiologic data. The exciting area of digital health allows multifaceted capture, documentation, and reporting of precise health conditions, triggering events, dates, times, and other contextual data. Some devices not only monitor the patient's disease status but also deliver medicine or therapeutic care. Using digitally enabled medical devices and their associated services, medical practitioners and payors can monitor patient conditions, while documenting use, functions, trends, conditions, environmental status, location, and other aspects of patient compliance, care, and necessities. Physicians and other qualified health care professionals can utilize home use medical devices to gather information associated with diagnosing, treating, or managing a clinical condition. Unlike before when this information was only captured episodically in between medical visits, the availability of this new information can help improve care management, leading to better patient outcomes, and potentially resulting in increased cost savings.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

The competitive bidding program for DMEPOS has created a severe reduction in the number of suppliers in general but has had a particularly devastating effect on suppliers who offer repair services for power wheelchairs. Medicare data confirms that there are 40 percent fewer standard manual and power wheelchair suppliers across the country since 2010.¹ This gap in the post-acute care space has led to patients, particularly in rural areas, to not be able to access needed repairs for medically necessary power wheelchairs. Without access to repairs, patients are isolated in their homes and lose their ability to perform activities of daily living.

Medicare utilization data confirms that beneficiaries have had access issues for certain frequently used repair items for standard power wheelchairs. For example, the utilization rate for E2370 (power wheelchair motor/gear comb), E2375 (non-expandable controllers), E2386 (foam filled drive wheel tire) and K0019 (arm pad) decreased at rates of over five times the utilization decreases for the base power wheelchairs, K0823.²

Communities have no way of rectifying the challenges that competitive bidding has created. Congress needs to address the issues that competitive bidding has created and increase payment levels in non-competitive bid areas consistent with H.R. 2771.

¹ 1 AAHomecare analysis of 2010-2018 Medicare DMEPOS supplier data obtained from CMS via FOIA requests; it includes suppliers providing the following product categories: hospital beds, wheelchairs (complex and standard), oxygen, RAD, CPAP, support surfaces, NPWT, ostomy items, urologicals, and enteral nutrition.

² CMS' Medicare claims data obtained from CMS via FOIA requests

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

Conducting Medicare claims data analysis for the provision of certain DMEPOS would prove very beneficial to determine if a disparity in the provision of services to beneficiaries exists based upon where they reside. Data could be analyzed to compare if the same percentage of beneficiaries residing in the rural/underserved area with similar diagnoses received the same percentage of DMEPOS as their counter parts residing in the metropolitan statistical areas (MSAs). Unfortunately, the necessary data elements cannot readily be obtained as a result of the de-identification standards required under the Health Insurance Portability and Accountability Act. Medicare claims data obtained under the Freedom of Information Act is stripped of beneficiary's zip code, thus rendering it useless for researching the disparity in the provision of service. A limited dataset which includes the beneficiary's full zip code should be made available for the purpose of analyzing the disparity in services provided to those residing in rural areas.

There are concerns with the classification of a rural area under DMEPOS. Unlike the standardized classification used for rural clinics and critical access hospitals, under the DMEPOS benefit, CMS defines "rural" to be a geographic area represented by a postal zip code of at least 50 percent of the total geographic area included in the zip code is estimated to be outside any MSA. This discrepancy has resulted in many rural areas erroneously being classified as non-rural areas. For the purpose of consistency and accuracy, we recommend CMS adopt the classification used by rural health clinics.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

In the 21st Century Cures law, Congress provided payment relief to DME suppliers servicing beneficiaries residing in rural areas, effective for services provided from July 1 through December 31, 2016. CMS extended this "rural relief" until CY2020 in their May 2018 Interim Final Rule.^{3,4} Congress and CMS provided this relief due to the rapidly decreasing number of DME suppliers and to ensure that the remaining DME suppliers can remain financially viable.

To ensure the suppliers servicing rural areas are able to keep their locations open beyond 2020, the rural relief needs to be made permanent. In addition, suppliers that serve beneficiaries in rural areas are generally the same ones that serve beneficiaries in the remaining non-competitive bid areas (CBAs). The issues of financial viability and beneficiary access do not start at the artificial

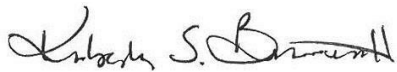
³ Pub-L. 114-255, Section 16007.

⁴ 83 *Fed. Reg.* 21912 (May 11, 2018).

“border” of the rural/non-contiguous and other remaining non-CBAs. Therefore, a relief for all non-CBAs are needed. H.R. 2771 would make permanent the rural relief provided by CMS (50%/50% blended rate), would provide additional relief for non-rural non-bid areas at a rate of 75% CBP-derived rates)/25% fee schedule rate, and would eliminate an outdated oxygen budget neutrality requirement. We urge Congress to pass H.R. 2771.

AAHomecare appreciates the opportunity to provide CMS with these recommendations, and we are happy to provide further details. Please contact me at kimb@aahomecare.org or (202) 372-0750.

Sincerely,



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VP for Regulatory Affairs