Legislative UPDATE

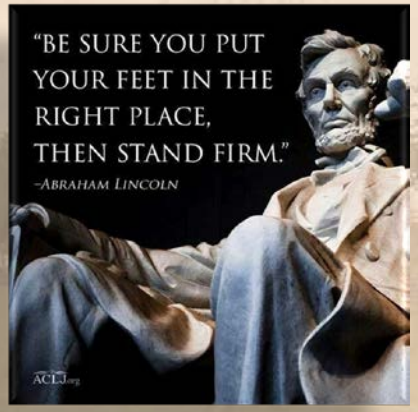
Why are things moving so slow in Washington?

August 10, 2017

John E. Gallagher
VGM & Associates

Industry Focus

With a NEW TRUMP Administration



TRUMPS First Executive Orders

Drain the Swamp!

The order does not offer specifics…the order directs agency heads to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications."

Making changes to CMS is like turning a barge

- Changes will not happen overnight
- Any changes have to be fought by career CMS
- Dr. Price currently fighting the Healthcare Reform battle
- Working with reduced Staff

Key DMEPOS Issues

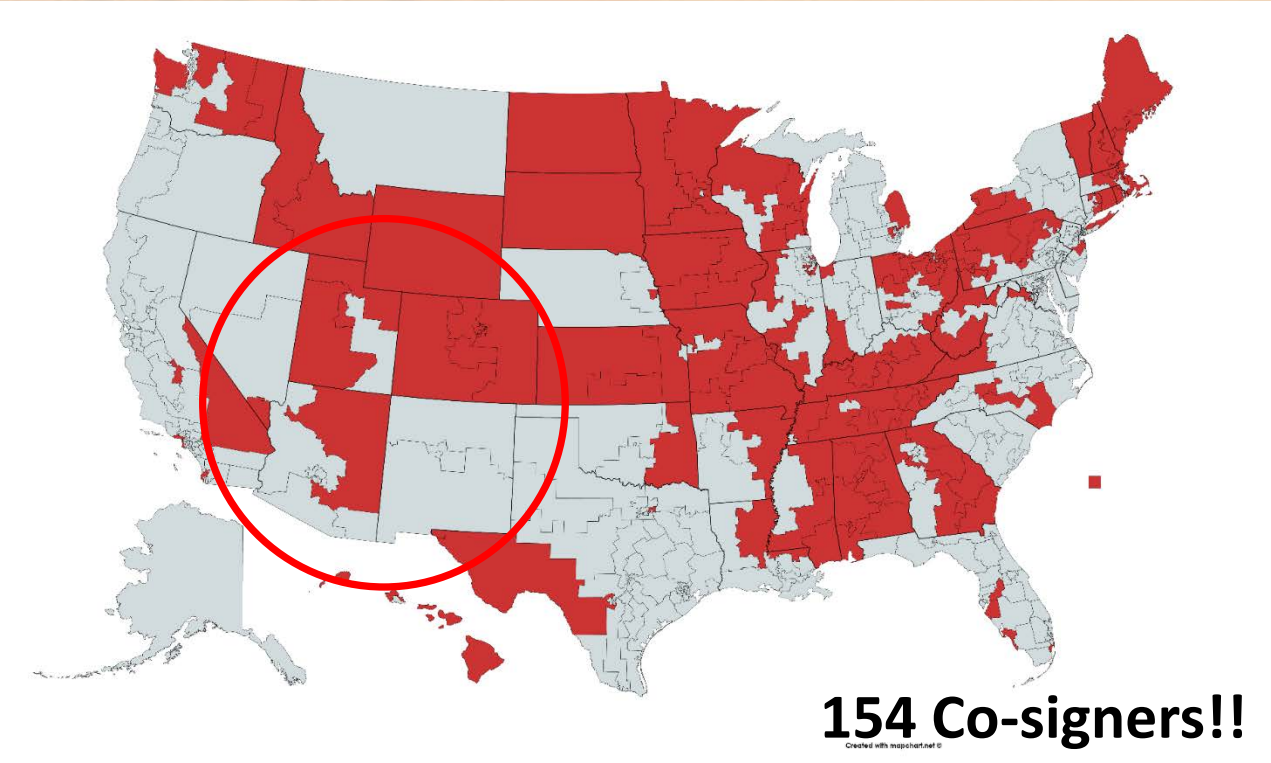
- *Reforming the Competitive Bidding Program to support sustainable reimbursement rates*
- *Combatting the oxygen "double dip" by CMS to reduce oxygen reimbursement rates.*
- *Congressional letters calling on CMS/HHS to implement reforms for DMEPOS*
- *Potential legislation coming from Rep. Cathy McMorris Rodgers on sustainable reimbursement rates*

Competitive Bidding Impact Survey

- Needing survey participants!
  - DME suppliers
  - Case managers/Discharge Planners
  - Patient/Caregiver

Dobson/DaVanzo & Associates online survey to determine access to care under the Competitive Bidding Program.

Sponsor Congressional Letter to HHS and CMS



Rep. McMorris-Rodgers (R-WA)

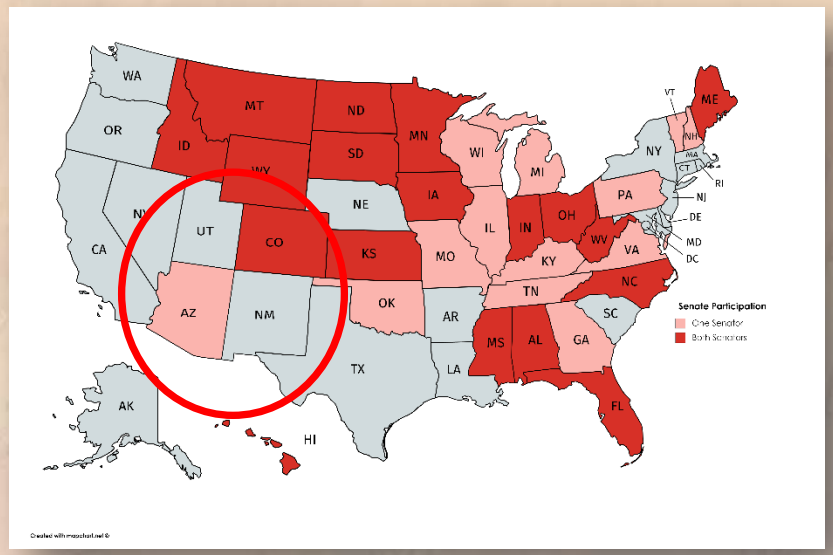
Rep. Loebsack (D-IA)

Rep. Zeldin (R-NY)

Rep. DeGette (D-CO)

Senate Letter to HHS/CMS

Sen. John Thune (R-SD)

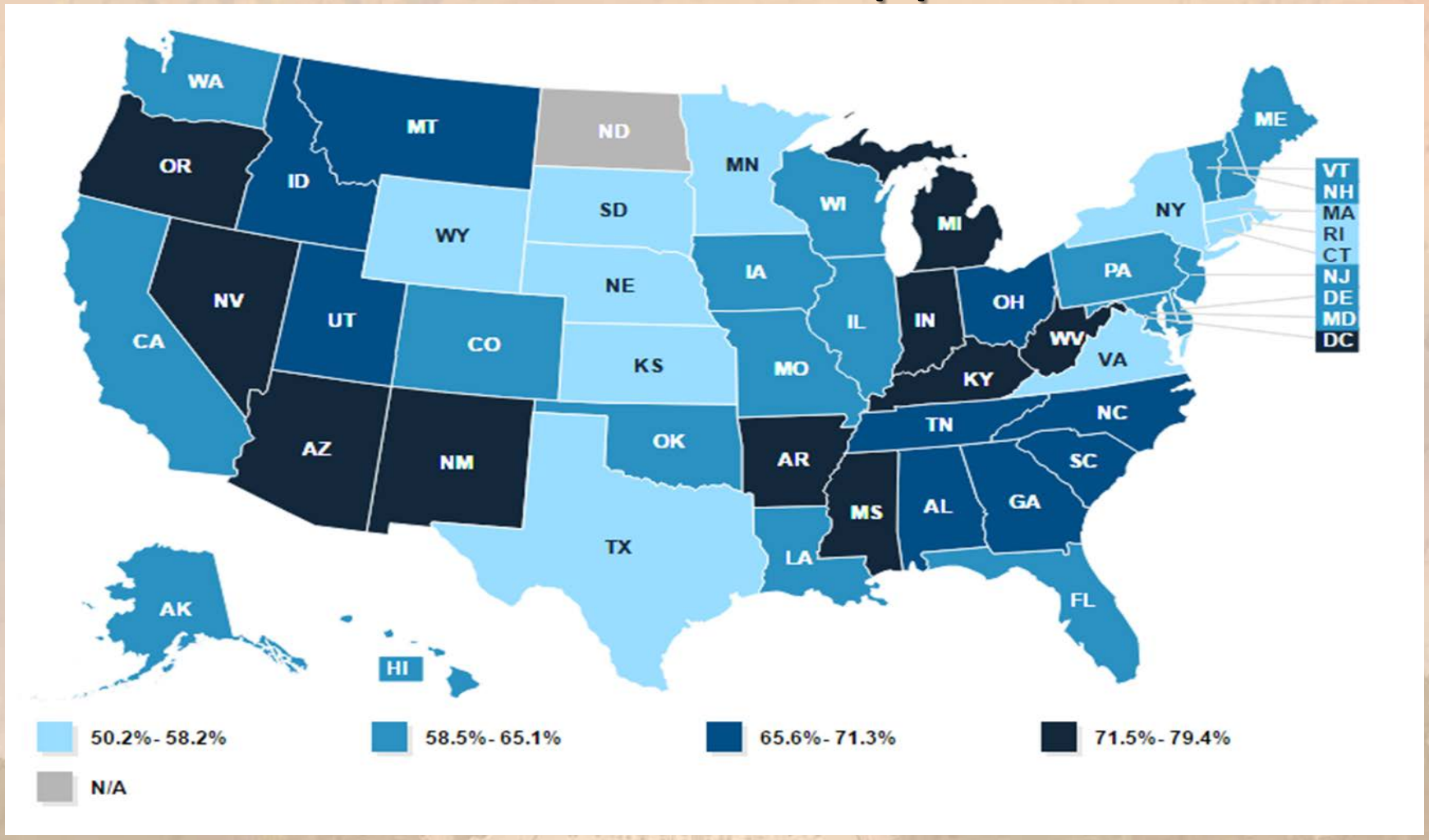


Sen. Heidi Heitkamp (D-ND)

49 Senate Signatures!

Addresses the key issue that impacts a vast amount of independent providers across the country are facing which is the high costs of providing care in non-competitively bid areas.

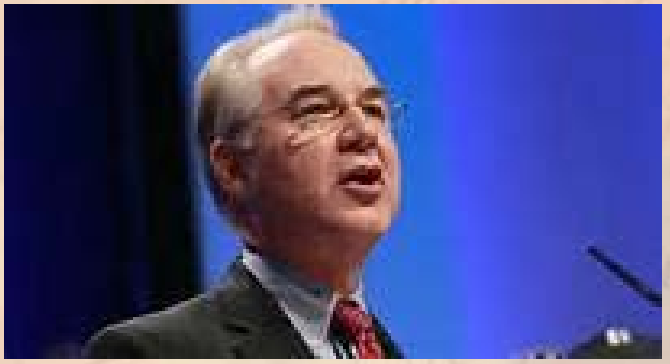
Level of Fed Medicaid Support to States



CURES Act moved 2019 Medicaid reimbursement to 2018

Long Term: Alternative to Competitive Bidding- MPP Pilot

Market Pricing Program



Rep. Tom Price (R-GA)
Vice Chair of Budget
Ways and Means

MPP would replace competitive bidding based problems that economist and auction experts identified in the current program.

Is the Money Rolling in Yet? "Mass Adjustments"

Suppliers that have started to receive payment from the adjustments related to the Cures Act. VGM would like to hear from you!

We would like to collect some data. When you start receiving payment, make us aware simply by shooting us an email, phone call, or text message. Along with any issues/concerns your company may be experiencing, for example, but not limited to:

- Filtering through the remittance summary in order to notice the payment,
- Any issues with posting in your billing software (and what is the billing software),
- Is it taking extra time for staff to work on the mass adjustments,
- Issues with crossover to secondary payer,
- Inquiries/concerns from patients related to the mass adjustments

We welcome examples of the remittance summary (EOB), so feel free to send over as well.

Need these meetings this Summer!

Sen. Orrin Hatch (R-UT)

Sen. Tom Udall (D-NM)

Rep. David Schweikert (R-AZ)

Rep. Ben Ray Lujan (D-NM)

Schedule your appointment now for the August recess!

Positive Steps…Hang in there!

Dr. Price has already had an immediate impact on DME:

- Receiving timely responses to inquiries
- Round 1, 2019 of CB was pulled immediately after it was introduced

Thank you SWMESA!!

This old soldier is working for you.

John Gallagher

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Congress Must Stop Drastic Cuts to DME Items in Rural & Non-Bid Areas

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 last December, statutorily extending the reimbursement rates in effect on January 1, 2016 to December 31, 2016 via the 21st Century CURES legislation. However, on January 1, 2017, the full cut took effect once more.

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%)**

Suppliers are still waiting to receive recoupments for claims impacted by the 21st Century CURES legislation. In May, 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

Congress has not had enough time to monitor disruption in Medicare beneficiaries' access to the HME items they need. Implementing the full cut on January, 1 2017 only exacerbates complications and beneficiary harm.

- **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

Our champions on Capitol Hill are working on legislation that will provide more time for Congress to evaluate the effects of bidding-derived pricing for rural and non-CB areas on patient access by establishing the Jan. 1, 2016 rates, in effect rolling back the second round of cuts that went into effect on July 1, 2016.

Our Ask:

The Southwest Medical Equipment Suppliers Association - SWMESA and AAHomecare strongly urges Members of Congress to become an original co-sponsor of forthcoming legislation that will provide relief for homecare patients and suppliers in non-Competitive Bidding areas.

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Congress Must Act to Protect Patient Access to Home Oxygen Therapy in Rural America

Issue

The Centers for Medicare and Medicaid Services (CMS) applied a budget neutrality "offset" to the 2017 rural fee schedules for stationary oxygen equipment. The result is that the 2017 payment rates for oxygen concentrators, HCPCS E1390, in rural areas are now well below the regional competitive bidding rates from which they were derived. CMS applied an outdated regulation that was never intended to apply to rates derived from Competitive Bidding rates, which has resulted in unstainable oxygen reimbursement rates in rural areas. While there are a number of legal opinions to the contrary of CMS' position, it appears that Congress needs to act quickly and pass legislation to protect Medicare oxygen patients.

Background

In 1997, Congress included in the Balanced Budget Act a provision that authorized CMS to pay for oxygen based on "classes", as long as the result was budget neutral. In response, in 2006, CMS used this authority to establish a new class of oxygen for new portable oxygen technology and called it oxygen generating portable equipment (OGPE). To comply with the budget neutrality mandate, CMS decreased the payment amount for stationary oxygen equipment. The payment decrease for oxygen concentrators was designed to account for increased expenditures for OGPEs as more beneficiaries used that technology.

In 1997, Medicare paid for DME based upon fee schedules. There was no Competitive Bidding program for DME and no Competitive Bidding rates. In addition, by its terms, the CMS regulation establishing the offset for oxygen concentrators applied to the unadjusted fee schedules under the fee schedule methodology mandated by Congress under § 1834 (a) of the Social Security Act (SSA).

In contrast, the 2017 fee schedules for concentrators in rural areas are based on information from the Competitive Bidding program under the methodology in SEC. 1847. [42 U.S.C. 1395w–3] of the Social Security Act. These two statutes, § 1834 and § 1847, describe different reimbursement methodologies that do not overlap. Regulatory sections 414.226 applies to fee schedules based on suppliers' reasonable charges from 1986 to 1987. Section 414.210 (g) applies to fee schedules based on regional average single payments amounts (SPAs) from competitive bidding areas (CBAs).

The following are examples of these drastic cuts for HCPCS 1390:

CBA Round	CBA Region	CBA Rate	1/1/17 Rural Rate	% Difference
RI 2017	Miami-Ft Lauderdale, West Palm Beach, FL	$90.01	$77.16	-14.28%
R2 ReCompete	Birmingham-Hoover, AL	$89.86	$77.16	-14.13%
R2 ReCompete	Knoxville, TN	$87.00	$77.16	-11.31%
R2 ReCompete	Raleigh, NC	$86.84	$77.16	-11.15%
R2 ReCompete	Albuquerque, NM	$86.09	$77.16	-10.37%

The Risk to Rural America

These implemented additional cuts to non-competitive bidding areas only exacerbates beneficiary access problems caused by Competitive Bidding.

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- **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:
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- **Unsustainable reimbursement is stripping communities of resources.** 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

Our champions on The Hill are working on legislation that will update the budget neutrality provision for oxygen which was enacted prior to the Competitive Bidding program.

Our Ask:

The Southwest Medical Equipment Suppliers Association - SWMESA and AAHomecare strongly urges Members of Congress to become an original co-sponsor of forthcoming legislation that will provide relief for homecare patients and suppliers in non-Competitive Bidding areas. Members of Congress should contact Representative Cathy McMorris Rodgers' office to become an original co-sponsor.

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Congress Must Act to Protect Access for People with Disabilities

Issue

On January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) began applying Competitive Bid Program (CBP) pricing to accessories used with Complex Rehab manual wheelchairs. This is contrary to Congress' intent and Medicare policies where CMS used its authority to exclude Complex Rehab manual wheelchairs from Competitive Bidding in 2010. Most important, the reduced payment rates create significant access problems for Medicare beneficiaries and other people with disabilities.

Although Congress requested that CMS rescind this policy, CMS did not change the policy. Therefore, Congress must pass clarifying legislation to accomplish this because:

- **It conflicts with Congress' intent.** In 2008, as part of the Medicare Improvements for Patients and Providers law (MIPPA), Congress prohibited CMS from including complex power wheelchairs, and accessories used with them, in the DME Competitive Bidding program. The only reason Congress did not include Complex Rehab manual wheelchairs is because CMS at the time had not included them in the bid program.
- **It conflicts with Medicare policies.** On its own authority, CMS excluded Complex Rehab manual wheelchairs from the bidding program, consistent with CMS' intent of exempting complex power wheelchairs from the program as part of MIPPA 2008.
- **It is based off pricing of different items.** CMS is using information obtained through the bidding of accessories used on Standard wheelchairs and is inappropriately applying that pricing to Complex Rehab accessories that were not part of the CBP. CMS elected to group heterogeneous products under the same HCPCS codes; as result, the same codes includes both Standard and Complex Rehab wheelchair accessories. Those products are fundamentally different, and bidding suppliers did not consider Complex Rehab accessories when submitting their bids as Complex Rehab wheelchairs and related accessories were not part of the CBP.
- **It detrimentally affects people with disabilities.** The negative consequences will not be limited to just the Medicare program but will extend to children and adults with disabilities covered by Medicaid and other health insurance plans since most other payers follow Medicare policies.

Background

Complex Rehab wheelchairs and related accessories are used by a small population of people with high levels of disabilities such as ALS, cerebral palsy, multiple sclerosis, muscular dystrophy, spinal cord injury, and traumatic brain injury. Within the Medicare program, these individuals represent a small but very vulnerable group of people with significant disabilities. Those who use manual Complex Rehab chairs are an even smaller population and account for only 2% of all Medicare beneficiaries who use wheelchairs. The specialized equipment is provided through a clinical team model and requires evaluation, configuration, fitting, adjustment, and/or programming. This small population has the highest level of disabilities and requires these individually configured Complex Rehab wheelchairs and critical related accessories to meet their medical needs and maximize their function and independence.

In November 2014, CMS issued Final Rule CMS 1614-F, which contains provisions relating to Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. These provisions detail how CMS will use information obtained through the Medicare CBP to adjust the Medicare Fee Schedule for Competitively Bid (CB) items provided in non-bid areas. In December 2014, CMS issued a "Frequently Asked Questions" document that states starting in 2016 it will use CB pricing information obtained from bids for Standard wheelchair accessories to reduce payment amounts for critical Complex Rehab wheelchair accessories (such as seat/back cushions, tilt/recline systems, and specialty controls). The payment changes went into effect January 1, 2016.

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Wheelchair accessories grouped under the same HCPCS code are very different and meet the needs of a different population of users. The accessories used with Complex Rehab wheelchairs have either not been included in the CBP at all, or the inclusion was so small that the data is insufficient to be reasonably used to adjust the national fee schedule.

Solution

Congressmen Lee Zeldin (R—NY) and John Larson (D—CT) are working on legislation which clarifies Congress' intent to exempt all Complex Rehab wheelchairs and accessories from the application of CB rates.

Our Ask:

In order to protect access to this Complex Rehab equipment for Medicare beneficiaries and other people with disabilities, the Southwest Medical Equipment Suppliers Association - SWMESA and AAHomecare strongly urges Members of Congress to become an original co-sponsor of this legislation that will protect access to Complex Rehab equipment and accessories for Medicare beneficiaries and other people with disabilities.

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