



## **HOME MEDICAL EQUIPMENT INDUSTRY CONCERNS - 2009**

### **Value of Homecare**

Homecare is the most cost-effective setting for healthcare in the United States. Former HHS Secretary Mike Leavitt has called home and community-based care “radically” more efficient than institutional care. The medical literature clearly documents this fact. Homecare is part of the solution for the long-term financial challenges that Medicare and Medicaid face as well as a valuable safety net for millions of Americans. Preserving and strengthening the nation’s homecare infrastructure is essential to the financial stability of the Medicare program.

### **Oxygen Reimbursement and the Post-36 Month Payment Policies**

#### **Issue:**

The Deficit Reduction Act capped reimbursement for Medicare home oxygen at 36 months. In many cases, the artificial cap prevents oxygen providers from receiving reimbursement for the entire period that medical necessity dictates beneficiaries are to receive oxygen. The cap on reimbursement imposes financial hardship on homecare companies. Moreover, the policy of capping payment jeopardizes Medicare beneficiaries’ access to continued care as well as the quality of care that they receive.

On October 30, 2008, CMS issued a final rule outlining Medicare payment policy for oxygen therapy that is provided after 36 months. These onerous, confusing and poorly thought-through rules were issued with no meaningful comment period. The rules established minimal and inadequate payment levels and unprecedented obligations that are impeding the provision of quality care to Medicare beneficiaries.

For example, under the rules, the original home oxygen provider must continue to provide, without any payment, unscheduled service and maintenance visits, 24 hour/7 day a week emergency care, equipment repairs, and oxygen supplies and accessories for a two-year period following the reimbursement cap. The rule also establishes inadequate payment levels for scheduled maintenance and service—

*“NEW ENGLAND’S UNITED VOICE FOR HME SERVICES”*

equal to two 30-minute visits annually at a payment rate of approximately \$30 per visit.

Patients and providers have begun seeing the detrimental effects of the recently implemented Medicare oxygen rule. The following examples are occurring across the country for oxygen patients who are at or nearing the 36-month rental cap:

1. A patient who would like to move out of the original provider's service area, but the provider cannot find a company in the new area that is willing to provide home oxygen therapy in the new location, due to the minimal payment levels.
2. A hospital that is looking to discharge a patient to a different area of the country is unable to find an oxygen provider and therefore cannot discharge the patient, forcing the Medicare program to pay for additional time spent in the hospital.
3. A patient who would like to switch providers cannot find another company willing to provide home oxygen therapy, due to minimal payment levels.
4. A company is going out of business and patients cannot find a new home oxygen provider, again, due to minimal payment levels.

**Request:**

Congress must restore oxygen payment policy for the period of medical necessity regardless of the time frame. Pending congressional action on removing the current cap, Congress should advise CMS to modify the existing post-36 month oxygen payment policies to address serious shortcomings that are creating hardships for both oxygen patients and providers.

Longer term, Congress needs to examine the Medicare home oxygen benefit to ensure (1) reimbursement policies recognize the services involved in the therapy; (2) home oxygen firms are treated as "providers" of health care services; (3) reimbursement continues for the entire time of medical necessity and is linked to specific patient need and provider cost; and (4) home oxygen is not subject to selective contracting through a competitive bidding arrangement.

**Complex Rehab 9.5 Percent Cut**

**Issue:**

When Congress enacted a delay of the DME competitive bidding program in the Medicare Improvements for Patients and Providers Act (MIPPA), a provision was included that exempted certain complex rehabilitative equipment from any future rounds of the competitive bidding program. Despite the fact that complex rehab was excluded, it is still subject to the 9.5 percent reimbursement cut in 2009 that was used to offset the cost of the competitive bidding delay. In excluding complex rehab from the bidding program, Congress recognized that the bidding program does not adequately address the difficulties imposed by serious injury or

disease, or the sophisticated equipment and services that are required to improve the lives of people with severe disabilities.

New Medicare HCPCS coding, coverage, and payment allowables have dramatically reduced utilization for these items and services, and complex rehab providers cannot continue to provide the same quality items and services with the additional 9.5 percent payment reduction. Consequently, Medicare beneficiaries' access to and quality of care will be severely impacted by this cut because providers may be forced to decrease essential services, reduce access to product trials and demonstrations, and provide substitute equipment that is not best-suited to each individual patient's needs.

**Request:**

NEMED recommends that Congress enact an exemption for complex rehab power wheelchairs and related accessories from the 9.5% cut in MIPPA so that Medicare beneficiaries will continue to have access to the high quality products and services.

**First-Month Purchase Option for Power Wheelchairs**

**Issue:**

Congress has made efforts to eliminate the Medicare beneficiaries' first-month purchase option for power wheelchairs. Currently, Medicare beneficiaries have the option either to purchase a power wheelchair when it is initially prescribed or to rent it for 13 months, at which time the beneficiary owns the equipment. Nearly all patients who meet Medicare coverage criteria elect the purchase option because they suffer from long-term, debilitating conditions that require customized equipment to meet their individual needs. Forcing these patients to rent power wheelchairs will create beneficiary access problems since providers will not be able to secure the financing to cover the costs of the power wheelchair over a 13-month period, especially given the current financial environment.

If the first-month purchase option is restricted or eliminated, it could have a crippling effect on a homecare provider's ability to continue to furnish power wheelchairs to Medicare beneficiaries. The proposal would require power wheelchair providers to secure lines of credit in order to purchase power wheelchairs in advance of delivery. If providers are unable to secure lines of credit, their ability to stay in business will be put at serious risk with the prospect of significant job losses.

**Request:**

The New England Medical Equipment Dealers Association recommends that Congress retain the first-month purchase option for power wheelchairs.

## **Competitive Bidding**

### **Issue:**

Competitive bidding for home medical equipment and products is a misguided policy that will significantly diminish the quality and continuity of care for millions of Medicare beneficiaries. Imposition of bidding will result in thousands of job losses in the homecare field within the first six months of the program's implementation. It will not promote competition—in fact, it will drastically reduce the number of providers available to serve the growing Medicare population. The program is akin to a selective contracting program, such as a closed-model HMO, which will result in government-mandated consolidation of an entire health care sector.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required that CMS make significant changes to the selective contracting (bidding) program. In enacting MIPPA, Congress intended for CMS to modify the program through the normal rulemaking process. The expectation of the House and Senate was that CMS would fix the troubled parts of the program that caused so much disruption last year for patients and providers and which ultimately led to the congressionally imposed delay. Instead, CMS issued an interim final rule on the program on Friday, January 16, 2009—the last possible day the Bush Administration could take regulatory action.

In publishing the rule as an interim final rule, CMS was not required to take into consideration comments from public before the rule goes into effect. More troubling is the CMS statement that “[MIPPA] did not alter the fundamental requirements contained in the competitive bidding program statute and regulations or revise the methodologies used by us [CMS] in calculating payment amounts and selecting suppliers.” CMS added that it would issue sub-regulatory guidance on numerous details that relate back to the changes required by MIPPA. This process will occur without any public comment or input.

### **Request:**

Congress needs to repeal competitive bidding in order to prevent both reduced access to care for Medicare beneficiaries and a decrease in the quality of care those beneficiaries receive. Providers of home medical equipment also face serious disruption to their businesses if competitive bidding becomes the primary mechanism for Medicare to determine reimbursement levels. We urge Congress to support H.R. 3790 to repeal competitive bidding for DMEPOS in a budget neutral manner.

## **Medicare Fraud & Abuse**

### **Issue:**

NEMED continues to vigorously support efforts to prevent Medicare fraud and abuse, which is theft of taxpayer dollars. The homecare community has a longstanding tradition of working with CMS and Congress to prevent fraudulent activity.

Medicare, however, needs to do more on this critical issue and including effective exercise of its already-ample authority to combat fraud and abuse. Medicare and its contractors must vastly improve their approach and do a better job at insisting on standards and other up-front controls that will deny illegitimate operators any chance of taking advantage of Medicare.

### **Request:**

Our national association, The American Association for Homecare has developed a comprehensive plan composed of 13 specific recommendations aimed at combating fraud and abuse in the Medicare program. These proposals should be enacted this year.