CQRC COUNCIL FOR QUALITY RESPIRATORY CARE

December 6, 2019

The Honorable Richard E. Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth Office Building
Washington, DC 20515

Re: Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady:

On behalf of the Council for Quality Respiratory Care (CQRC), I am writing to thank you for providing us with the opportunity to submit comments to inform the Rural and Underserved Communities Health Task Force as it works to develop bipartisan legislation to improve health care outcomes within underserved communities. The CQRC is a coalition of the nation's seven leading home oxygen and sleep therapy providers and manufacturing companies. Together we provide in-home patient services and respiratory equipment to more than 600,000 of the more than one million Medicare beneficiaries who rely upon home oxygen therapy to maintain their independence and enhance their quality of life. Similarly, we provide homecare services, equipment and supplies to more than one million Medicare beneficiaries with Obstructive Sleep Apnea (OSA).

In the area of home respiratory therapy, as well as other durable medical equipment, adequacy of payment rates is one of the greatest, if not the greatest, challenges facing patients, health care providers, and suppliers. CMS has adopted a policy that applies the competitive bidding (CB) rates to areas that the Congress excluded from the competitive bidding program (CBP). In implementing this policy, CMS divides these non-competitive bidding areas (non-CB areas) into rural and non-rural. The rural areas receive a 10 percent increase in the CB-derived rate, while the non-rural non-CBAs are paid at the CB-derived rate. In addition, CMS continues to apply an outdated budget neutrality calculation to home oxygen therapy in all non-CB areas that results in the home oxygen concentrator being reimbursed in these areas at rates which, in some cases, are 10 percent less than the concentrator rates in CB areas.

As 2014 data shared with CMS from the CQRC companies showed, the cost of providing services in non-CB areas was 13 percent higher than the costs in CB areas, on average. This cost survey also showed that the costs in areas defined by CMS as "super-rural" under the Ambulance Fee Schedule (which stand as a proxy for the currently defined rural non-CB areas) were on average 17.5 percent higher than those of CB areas, while the costs in the remainder of the non-CB areas were 11 percent higher. In addition, this survey found that the actual cost of providing services in CB areas on average were 5 percent

higher than the average Single Payment Amounts (SPAs) used in the CB areas, showing that the SPAs are below the cost of providing items and services even in the CB area. Thus, the total amount that the SPA rates are below the cost of providing services in non-CB areas for CQRC companies is 18 percent. This survey focused on the national and large regional home respiratory therapy suppliers who are members of the CQRC. Given their efficiencies and economies of scale, we anticipate that if a similar survey were conducted of all home respiratory therapy suppliers, the costs would be somewhat higher.

The Congress recognized the problems the non-CBA payment policies created and the risk of the loss of access to life-sustaining home respiratory therapy that beneficiaries face because of inadequate payment rates when it extended the transitional blended rate through legislation. CMS also postponed the application of these policies by extending the blended rate through the end of December 2020. However, that extension is close to expiring.

We agree that it is important to address the questions outlined in the RFI, but also encourage the Task Force to consider payment issues, such as these. Therefore, we ask that the Task Force consider supporting in its recommendations the provisions of H.R. 2771, the "Protecting HOME Act of 2019," introduced by Reps. Cathy McMorris Rodgers (R-WA) and David Loebsack (D-IA). This legislation would address both of the non-CB area rate issues and protect access to home therapies that allow patients to remain in their homes and communities and reduces overall costs to the Medicare program.

I. Response to RFI Questions

Below are our responses to the questions asked by the RFI with our answers limited to 250 words or less.

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?

Individuals living with chronic diseases that require home respiratory therapy face serious challenges to accessing the care they need to remain in their homes and communities. As noted above, adequate reimbursement is critical to ensure that access.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food

insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

As "suppliers," home respiratory therapy suppliers have not been allowed to directly participate in models that may address these issues. However, through work with managed care organizations and other types of commercial insurers, our members have been able to help reduced readmissions and hospitalizations, particularly for COPD patients, by providing services that help patients adhere to their treatment regimens. Such intervention is possible only with adequate reimbursement.

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

In the context of home respiratory therapy, the volume of patients in a service area has a dramatic impact on the cost of providing services. In urban areas, the potential for increasing the volume of items and services provided in CB areas allows suppliers to bid at rates that are lower than they would be in non-CB areas where any willing provider may supply the items and services. These suppliers anticipate being able to spread the fixed costs of providing the items and services over more beneficiaries, thus creating economies of scale. Suppliers take these volume-related factors into account when bidding. However, such factors are not the same in non-CB areas. Therefore, applying CB-derived rates to non-CB areas does not adequately take into account the effect of the patient volume on the cost of providing services. To the extent CMS continues to use the CB-derived rates as the basis for non-CB areas rates, we ask the Task Force to support H.R. 2771 to protect access to patients in these areas.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? b. there is broader investment in primary care or public health? c. the cause is related to a lack of flexibility in health care delivery or payment?

We do not have experience to answer this question.

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?

We do not have experience to answer this question.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

We know of no models addressing workforce shortages related to home respiratory therapy.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

This question is outside the scope of our members' expertise.

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?

While we do not have experience with a community-specific approach, we do know that providing home therapies in rural areas is more difficult than in urban areas. It is also critically important to maintain access to these therapies as hospitals and other post-acute care facilities reduce hours or even leave rural communities. Home respiratory therapies allow patients to remain in their homes with their families and remain active in their communities. But, the application of CBA derived rates to non-CB areas places patients with chronic respiratory disease for which home therapies are an appropriate option, at risk of having to move to facility-based care or leave their communities to receive home care. As noted above, adequately reimbursement for these services would address this problem.

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?

To protect access to home respiratory therapy, we recommend that the Congress and other policymakers monitor the number of suppliers in each individual geographic area CMS has created for the CBP (defined as CB areas; non-CB areas non-rural; non-CB areas rural) to determine if patients have actual choice of suppliers through PTAN and claims data. It is important to make sure that policies promote suppliers with a physical presence in the geographic areas.

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?

Providing adequate funding that addresses the higher fixed costs in rural areas, along with the need for additional personnel and higher transportation-related costs, would strengthen the Medicare home respiratory benefit in a way that would protect access to high quality care for patients.

II. Conclusion

The CQRC appreciates having the opportunity to provide comments. We look forward to working with the Task Force to protect access to home respiratory therapies by providing adequate reimbursement in the Medicare program. Please do not hesitate to contact Kathy Lester, CQRC's Executive Director, at klester@lesterhealthlaw.com or 202-534-1773 if you have questions about these comments.

Sincerely,

Dan Starck
Chairman, Council for Quality Respiratory Care

cc: The Honorable Brad Wenstrup
The Honorable Jodey Arrington
The Honorable Danny Davis
The Honorable Terri Sewell