

December 6, 2019

Rural and Underserved Task Force  
Committee on Ways and Means  
U.S. House of Representatives  
1102 Longworth Office Building  
Washington, DC 20515

Via E-mail at: [Rural\\_Urban@mail.house.gov](mailto:Rural_Urban@mail.house.gov).

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

Thank you for initiating a Request for Information related to the Rural and Underserved Communities Health Task Force as it works to develop bipartisan legislation to improve health care outcomes within underserved communities. We applaud you for undertaking this important work and Lincare is pleased to provide information related to home oxygen and respiratory therapy services as well as home INR testing for the Medicare population taking the drug warfarin.

**I. Introduction**

Lincare is one of the nation's largest home care providers. We provide services and equipment to patients in the home from over 800 operating locations in 48 U.S. states, and we employ approximately 13,000 people. The vast majority of patients served are Medicare beneficiaries.

Additionally, Lincare provides an important service that allows for patients to self-test their blood at home for the management of anti-coagulant therapy. Approximately 4 million people in the United States take the blood thinner warfarin (brand name Coumadin®) and 3 million of those individuals are Medicare beneficiaries. Patients on warfarin rely on regular weekly blood tests to monitor their levels of clotting factor and reduce their risk of stroke or hemorrhage. Such testing is a critical part of physician care-planning and safety monitoring for these patients.

For many of these patients, home testing has been a patient-friendly option to minimize lab or physician office visits. Patients who self-test have demonstrated the ability to achieve improved therapeutic benefits resulting in fewer hospitalizations, reduced occurrence of stroke, and reduced drug related complications. Home testing is supported by licensed clinicians with state of the art equipment and supplies. It requires in-person training and education for the patient or care-giver, as well as regular compliance monitoring. Weekly test results are reported to physicians to ensure dosages are at a therapeutic level. Clinical software is an integral part of the system, enabling physicians to remotely monitor patients.

Some of the analytical work surrounding home International Normalized Ratio (INR) testing has demonstrated that physicians appear more likely to try home INR testing for their more rural patients. This makes sense when you consider the travel burdens Medicare beneficiaries would otherwise confront in seeking out office based testing for their regular monitoring.

Patients that test at home average 4.0 tests per month compared to 1.7 tests per month for patients relying on other testing sites. Not coincidentally, complication rates are lower for patients who rely on home INR testing compared to patients who test outside the home.

Despite the importance of regular testing and the value of home testing for patients on warfarin, CMS has reduced reimbursement for self-testing by 52% since 2017. The reimbursement reductions occurred because the pricing for testing in the home is calculated as if it were done in a physician's office. This does not account for indirect costs such as those associated with home visits by licensed clinical staff, additional capital equipment to allow for each patient to have a testing device in the home, and continued patient follow-up calls for compliance monitoring.

As a result of the reduction in reimbursement, CMS has significantly undermined a successful example of remote monitoring in the Medicare program. The Rural and Underserved Communities Health Task Force is to be commended for your important work in encouraging treatment options that allow Medicare beneficiaries to receive the care they need and deserve in the settings they prefer. CMS should be encouraged to stabilize reimbursement for home INR testing rather than creating disincentives for home-based options that utilize technology.

Lincare is a member of the Council for Quality Respiratory Care ("CQRC"). Lincare agrees with their comments and reiterates them below.

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 challenge facing patients, health care providers, and suppliers. CMS has adopted a policy that applies the urban competitive bidding rates to areas that the Congress excluded from the competitive bidding program (CBP). In implementing this policy, CMS divides these non-competitive bidding areas (CBAs) into rural and non-rural. The rural areas receive a 10 percent increase in the rate, while the non-rural non-CBAs are paid at the CBA rate. In addition, CMS continues to apply an outdated budget neutrality calculation to home oxygen therapy that results in the home oxygen concentrator being reimbursed in non-rural CBAs at rates below (in some cases 10 percent less) the rates in CBAs and at the CBA rates in rural areas.

As 2014 data shared with CMS from the CQRC companies showed, the cost of providing services in non-CBAs was 13 percent higher than the costs in CBAs, 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-CBAs) were on average 17.5 percent higher than those of CBAs, while the costs in the remainder of the non-CBAs were 11 percent higher. In addition, this survey found that the actual cost of providing services in CBAs on average were 5 percent higher than the average Single Payment Amounts (SPAs) used in the CBAs, showing that the SPAs are below the cost of providing items and services even in the CBAs. Thus, the total amount that the SPA rates are below the cost of providing services in non-CBA 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 create 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-CA) and David Loebsack (D-IA). This legislation would address both of the non-CBA 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.

## **II. 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 INR testing or 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. On average, Medicare beneficiaries performing INR testing in their home through the services of Lincare, would have to drive an average of 45 minutes one way to get to their prescribing practitioner’s office to have the simple blood test completed if the service was not available in their homes.

### **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 a supplier, Lincare has 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, has been able to help reduced readmissions and hospitalization, particularly for COPD patients and patients receiving the drug warfarin by providing services that help patients adhere to their prescribed 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 CBAs allows suppliers like Lincare to bid at rates that are lower than they would be in non-CBAs where any willing provider may supply the items and services. These suppliers anticipate being able to spread the fixed costs of providing these items and services over more beneficiaries, thus creating economies of scale. Thus, suppliers take these volume-related factors into account when bidding; however, such facts are not the same in non-CBAs. Therefore, applying CBA rates to non-CBAs 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 CBA rates as the base for non-CBA 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?

Lincare does 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?

Lincare does 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 the services provided by Lincare.

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?

Lincare does not have experience to answer this question.

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 Lincare does 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 rates to non-CBAs 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 CBA; non-CBA non-rural; non-CBA 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.

Likewise, Lincare recommends that Congress and policymakers monitor the number of Independent Diagnostic Testing Facilities (“IDTF”) in the INR patient self-testing space. Currently, the industry down to about three large national IDTFs and a handful of smaller IDTFs. Unfortunately, with the drastic cuts in reimbursement, there is likely to be continued consolidation leading to additional beneficiary access.

**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 address the higher fixed costs in rural areas, along with the need for additional personnel and higher transportation-related costs, would strengthen both the Medicare home respiratory benefit and patient INR self-testing benefit in a way that would protect access to high quality care for patients.

**III. Conclusion**

Lincare appreciates having the opportunity to provide comments. We look forward to working with the Task Force to protect access to home respiratory therapy services and patient INR self-testing by providing adequate reimbursement within the Medicare reimbursement system. Please do not hesitate to contact Jenna Pedersen, Chief Compliance Officer, at [jpederse@lincare.com](mailto:jpederse@lincare.com) or 727-530-7700 if you have questions about these comments.