

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?

*Lowered reimbursement rates due to the competitive bidding program have significantly affected access to quality medical equipment products and services since the onset of the program. Since the implementation of this program over ten years ago, this program has consistently driven Medicare reimbursement rates to a level that make it impossible to provide quality and timely products to Medicare beneficiaries. As a result, Medicare beneficiaries are spending extra days in the hospital until they receive the equipment they need to heal at home. They are also ending up back in the hospital due to not receiving the equipment they need to keep them safe in the home.*

*Currently there is legislation, H.R.2771-Protecting Home Oxygen and Medical Equipment Act of 2019, that would provide an increase in reimbursement specifically in rural areas of the country where a significant amount of Medicare beneficiaries reside. This increase in reimbursement would provide HME suppliers the ability to deliver to rural areas in a timely manner.*

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?

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

*The amount of HME suppliers in each state have significantly decreased since the onset of the competitive bidding program. Many “snowbird” states have seen a decrease in HME suppliers as much as 50% since the competitive bidding program began over ten years ago. Decreased reimbursement rates due to the program have been a direct result of the HME closures and acquisitions. See this map with DME closures over the past 10 years.*

*<https://www.vgmdclink.com/uploads/Document-Library/0226755a6f134a1d48dbf804655111a1.pdf>*

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?

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?

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful? Critical Access Hospitals (CAH) are one such model. Congress created the CAH designation through the Balanced Budget Act of 1997 (Public Law 105-33) in response to a string of rural hospital closures during the 1980s and early 1990s. Since its creation, Congress has amended the CAH designation and related program requirements several times through additional legislation.

*The designation has succeeded in that it is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. To accomplish this goal, CAHs receive certain benefits, such as cost-based reimbursement for Medicare services. This is not the case for DME suppliers. As W&M members are most aware, with continued reimbursement cuts and inadequate funding, many rural DME suppliers have been forced to stop taking assignment, leaving beneficiaries to shoulder expenses up front out of pocket. This is creating a two-tier system for Medicare beneficiaries; those who can afford to personally gap-fill and compensate for the severe underfunding by Medicare of essential DME supplies, and services, and those who go without. Further jeopardizing beneficiary access to care, trusted DME companies across rural and non-competitively bid America now report making significant changes to their business model as result of Medicare reimbursement falling below suppliers' costs, such as changing delivery and service policies, reducing product offerings, closing branch locations, and/or shuttering their businesses entirely. Currently there is legislation, H.R.2771-Protecting Home Oxygen and Medical Equipment Act of 2019, that would provide an increase in reimbursement specifically in rural areas of the country where a significant amount of Medicare beneficiaries reside.*

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?

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?

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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?

*There are arguments that the lower reimbursements applicable to Medicare competitively bid DMEPOS items for patients residing in non-CBA areas are insufficient in that these patients allow suppliers to receive a “regional single payment amount” that approximates the competitive bid contract payment. These amounts average 50-60% lower than the “rural” payments allowed by CMS-1687-IFC. It increased the fee schedule rates DME and enteral nutrition to the “blended” 50/50 formula and was extended to 2021 by the “CURES” Act. However, it only applies to “rural” and non-contiguous areas of the country (about 50% of non-CBAs and about 20% of the patient population). We opine the definition of “rural” should be expanded to allow appropriate reimbursement in non-metropolitan – but not “rural” areas. To wit: “rural areas” applicable to Rural Health Clinics and Critical Access Hospitals are defined by ZIP codes via a formula that is directed by the US Census Bureau and defined at 42 CFR 491.5.*

*Note that this definition is different from that of a metropolitan statistical area (MSA). There is also further consideration of “shortage”:*

- *As an area with a shortage of personal health services under §330(b)(3) or 1302(7) of the PHS Act;*
- *As a health manpower shortage area described in §332(a)(1)(A) of the PHS Act;*
- *As an area which includes a population group which the Secretary determines has a health manpower shortage under §332(a)(1)(B) of the PHS Act;*
- *As an area designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services.*

*But for DMEPOS, the ZIP codes for areas defined as rural areas per regulations at 42 CFR 414.202. Rural area means, for the purpose of implementing § 414.210(g), a geographic area represented by a postal zip code if at least 50 percent of the total geographic area of the 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 to 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?

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