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Centers for Medicare & Medicaid Services
DMEPOS Adjusted Fee Methodology for Non-Bid Areas:
Stakeholder Input on Section 16008 of the 21st Century Cures Act Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
March 23, 2017
2 pm ET

Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® Listening Session. All lines will remain in a listen-only mode until the feedback session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect.

I will now turn the call over to Leah Nguyen. Thank you, you may begin.

Announcements and Introduction

Leah Nguyen: Hello, everyone. Thank you for joining us today. I am Leah Nguyen from the Provider Communications Groups here at CMS. Welcome to this MLN Connects Listening Session focused on the DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act. MLN Connects Calls are part of the Medicare Learning Network®.

This listening session provides an opportunity for CMS to receive feedback from stakeholders on statutorily required changes to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, or DMEPOS, Adjusted Fee Schedule Methodology for Non-Bid Areas. Section 16008 of the 21st Century Cures Act mandates stakeholder input on the methodology for using information from the competitive bidding program for adjusting Medicare fee schedule amounts paid in non-competitive bidding areas. During this call, CMS will talk about the new legislation, and then you'll be given an opportunity to provide feedback. This call will not include a question-and-answer session. CMS will not be responding to questions.

Before we begin, I have a few announcements.

There is a slide presentation for this call. You should have received a link to the presentation in your registration and confirmation emails. If you've not already done so, please view or download the presentation from the CMS website at go.cms.gov/npc. Again, that's go.cms.gov/npc. Select today's date from the list and click on Slide Presentation under Call Materials.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website under Call Materials. We will put an announcement in the MLN Connects Provider eNews when these are available.

At this time, it is my pleasure to turn the call over to Joel Kaiser.

Presentation

Joel Kaiser: Thank you, Leah. Hi. I'm Joel Kaiser. I'm the director of the Division of DMEPOS Policy in the Center for Medicare at CMS.

If everyone who has the slides can turn to slide 4. This slide lists the agenda for the call. I will be providing a brief presentation on the legislative and regulatory requirements for competitive bidding as well as fee schedule adjustments for areas where competitive bidding programs have not yet been phased in. I will briefly summarize Section 16008 of the 21st Century Cures Act, and then we will open the line for input from stakeholders.

Background: Legislative and Regulatory Framework

If you turn to slide 5, this slide addresses the legislative framework for competitive bidding. The Medicare statute mandates implementation of competitive bidding for contract award purposes for furnishing DME, durable medical equipment, and enteral nutrition in areas throughout the United States. These rules are located in Section 1847 of the Social Security Act and form the payment basis for these items and services. The statute mandates that the programs be phased in first in 100 of the largest metropolitan statistical areas with the phase in of additional areas after 2011.

Turning to slide 6, this slide addresses the regulatory framework for competitive bidding. Contract suppliers are required to furnish items throughout the entire competitive bidding area. Suppliers in competitive bidding areas also include grandfathered suppliers for rented DME. These are suppliers who have – were furnishing rented DME at the time the programs began and can elect to furnish those items to existing patients once the program begins in these areas. There are also limited exceptions for certain items furnished by physicians and hospitals.

Section 16008 of the 21st Century Cures Act

Turning to slide 7, this slide addresses the statutory requirement to adjust fee schedule amounts for DME in non-bid areas based on the payment amounts determined under competitive bidding. In all areas where competitive bidding programs are not established for specific items and services, payment continues to be made on a fee schedule basis in accordance with the Exclusive Payment Rule of Section 1834(a) of the

Social Security Act for durable medical equipment and the Discretionary Payment Rule at Section 1842(s) of the Social Security Act for enteral nutrition.

Under Section 1834(a), the statute mandates that by no later than 2016, the fee schedule amounts used in paying claims for DME in all areas where competitive bidding has been established for the items and services be adjusted based on information from the payment determined under competitive bidding programs. Section 1842(s) provides discretionary authority to do the same for enteral nutrition. Section 1834(a) mandates that the methodology for adjusting the fee schedule amounts for DME be promulgated through notice and comment rulemaking and that this rulemaking consider the cost of items and services in areas in which the payment adjustments would apply compared to the payment rates established in competitive bidding areas.

Rulemaking was conducted in calendar year 2014 and provided for adjustments to the fee schedule amounts for areas within the contiguous United States based on the average of the payment rates established in competitive bidding areas in eight regions of the country. The regional adjusted fee schedule amounts are limited by a national floor and ceiling equal to 90 percent and 110 percent of the average of the regional adjusted fee schedule amounts. Adjustments for areas outside the contiguous United States are based on the higher of the amounts established in the Honolulu, Hawaii, competitive bidding area or the national ceiling amounts established for the contiguous United States.

In response to comments on the proposed rule, the national payment ceiling is used to adjust fees for all areas within the contiguous United States that are not located in a metropolitan statistical area or which have been excluded from a competitive bidding area because it is a low-population density area. In addition, the adjusted fee schedule amounts were phased in so that the fee schedule amounts for the first 6 months of 2016 was based on a – on 50 percent of the unadjusted fee schedule amount and 50 percent of the adjusted fee schedule amount. The current fee schedule methodology – adjustment methodology was modeled closely after an industry proposal from 1987 that led to the legislation establishing an initial regional fee schedule structure for DME as well as the current regional fee schedule structure for prosthetics and orthotics.

Slide 8 provides a summary of Section 16008 of the Cures Act. And this section requires that in making fee schedule adjustments for items and services furnished on or after

January 1, 2019, we are required to take into account the highest amount bid by a winning supplier in a competitive bidding area. We are also required to take into account a comparison of three factors with respect to non-competitive bidding areas and competitive bidding areas. The three factors are, one, the average distance – travel distance and cost associated with furnishing items and services in the area; two, the average volume of items and services furnished by suppliers in the area; three, the number of suppliers in the area. The statute also mandates that we solicit and take into account stakeholder input, which is the purpose of this call today.

So this completes the overview presentation, and we will now begin the stakeholder input portion of the call.

Keypad Polling

Leah Nguyen: Thank you, Joel.

In just a moment, we will start the listening session portion of the call. But, before we do, we will pause to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. There will be a few moments of silence while we tabulate the results.

Holley, we are ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling. Again, please hold while we complete the polling.

Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Leah Nguyen.

Listening Session

Leah Nguyen: Thank you, Holley.

We will now start the listening session portion of this call. There will be three segments to this listening session. The first group of suppliers we would like to hear from are suppliers service large expansive areas with low population. The second group of suppliers we would like to hear from are suppliers servicing the non-contiguous areas. The third group of suppliers we want to hear from are all other suppliers.

Before we begin, I would like to remind everyone that this call is being recorded and transcribed. CMS will be listening to your feedback. We will not be responding to questions about the legislation at this time. Before providing your feedback, please state your name, the name of your business, where your business is located, your ZIP Code, the item you furnish, and which area you serve. Remember to pick up your handset to assure clarity. Please note your line will remain open during the time you are providing your feedback, so anything you say or any background noise will be heard in the conference.

Comments from Suppliers Serving Large Expansive Areas with Low Populations

We are now ready to take comments about the first group of suppliers, those suppliers serving large expansive areas with low population.

Operator: To provide your feedback, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key.

Please hold while we compile the roster. Again, please hold while we compile the roster.

Please continue to hold while we compile the roster.

Our first question comes from Rebecca Erickson. And that feedback has been withdrawn.

Please hold while we compile the roster. Our next feedback comes from Julia Humphrey.

Julia Humphrey: I'm calling from Reno, Nevada, and we service a large area going all the way approximately 5 hours to the east of us going to Ely, Nevada. We also service a rural area called Hawthorne, Nevada, and go all the way up to rural northern – or, excuse me, rural eastern California: Portola, Quincy, Susanville area. This is a – it is a huge amount of effort getting out to these areas, and these populations are very underserved.

I realize that, you know, we just need to please make sure that we account into mileage and everything else. The POCs are something – portable oxygen concentrators are items that we provide. And the reimbursement rate barely covers the cost of the equipment, let alone the driver's time, the setup, the maintenance, the tubing. Tubing is a huge issue in my eyes. There's absolutely zero reimbursement. And when your cost exceeds the reimbursement, there's problem, and these people are going to go without. And that's my biggest concern at this point. I don't know how you can possibly service these rural areas for the fee schedule that we're receiving at this point.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Rebecca Erickson.

Rebecca Erickson: Thank you for taking the time to listen to those of us on the forefront who have been struggling to stay afloat and keep our heads above water this last year. Last year's Medicare cuts have drastically affected our business. We are located in rural Wyoming, and we're the only local provider that services this area. We service an area roughly 40 miles to the north and 50 miles to the south and often receive calls well out of our area for those who have lost their local DME providers due to the drastic cuts.

As a rural provider, we don't get volume discounts. With the new fee schedule, which pays only $96.09 for full-face masks, We are now set up to lose money on each mask that we distribute.

For CPAP machines, the new fee schedule amount is $439.50 divided by 13 months. After we deduct the cost of our machine and paying our respiratory therapist to set the machine, that leaves us a total of $4.50 profit. That $4.50 is expected to cover all of our time educating, gathering the initial and recertification paperwork, billing every month for 13 months as well as continued support and care of our customers. We also run the risk of the patient not complying or giving up on their CPAP machine and returning the machine, and then we are at an even greater loss.

Our oxygen reimbursement has been cut by nearly 60 percent. How many individuals would be able and willing to work for 40 percent of their current paycheck and how long would you be expected to work to support your family under those circumstances? Our market needs to cover the cost of our supplies and equipment, the cost associated with doing business, which is servicing equipment, accreditation fees and costs, which is about, for our business, $6,000 every 3 years, liability insurance and surety bonds that are required by Medicare and, at the end of the day, create profit sufficient enough to support our growing family of five.

We have been forced to dig into our own personal and savings accounts to keep our business afloat this last year and continue to provide the much-needed supplies and services in our area in an attempt to maintain our customer base in anticipation that Medicare will right this wrong. We ask that Medicare expedite the payment of funds due for the 21st Century Cures Act. We are doing all that we can to stay afloat. But we can only tread water so long before we go under.

And just to reiterate, my name is Rebecca Erickson. Our business is Star Valley Medical Supply. We are located in Afton, Wyoming, ZIP Code 83110. We supply oxygen, CPAP, walkers, wheelchairs, that sort of thing. And, again, we service about a 90-mile stretch of highway and about 30 to 40 miles off of that highway to the east and west as well as other underserviced areas that do not have providers in Wyoming. Thank you for your time.

Leah Nguyen: Thank you.

Operator: Our next comment comes from Ronnie Rankin.

Ronnie Rankin: Yes. I'm Ronnie Rankin with Culpeper Home Medical. Thank you, again, for letting us do input today. I concur with everyone that has spoken so far as far as the bid rates or as far as the reimbursement rates being too low. Hospital beds here in central Virginia are down to $38.46 a month for the last 10 months of the rental. Quite honesty, we can't even get out the door for what the reimbursement is doing. And here in central Virginia, we deal with the rural areas not just here in central Virginia but across the Blue Ridge Mountains. Some of clients are hours – an hour and a half away. And that is on if you don't account any weather, which is pretty common with the mountainous area.

So, again, we'd like to see a fast resolution to the Cures Act and definitely some – a better reimbursement rate based on a lot of factors that you deal with in the rural area. Thank you.

Leah Nguyen: Thank you. Could we get your name and your company, please?

Ronnie Rankin: Ronnie Rankin, Culpeper Home Medical.

Leah Nguyen: And your ZIP Code?

Ronnie Rankin: 22701.

Leah Nguyen: Okay. Great Thank you.

Ronnie Rankin: Yes.

Operator: Our next comment will come from the line of Josh Shields.

Josh Shields: Good afternoon. This is Josh Shields. Can you hear me?

Leah Nguyen: Yes, we can.

Josh Shields: Very good. I'm with Beta Med, and we are located in Bryan, Texas. We are – area code 77 – or excuse me – ZIP Code 77802 for us. We cover roughly 60 to 90 to 100 – 60 to 100 miles, depending on the direction that you go from our office. We're hemmed in on two sides by CBA areas. But there is very limited, I guess, infiltration of those CBA company winners in those areas coming to the rural area because they're doing all they can to service their existing area.

We – a couple of things. One, when the CBA bid prices were bid, those bids – those bidders determined those prices knowing that they would – there would be limited competition. So, there would be bid winners and no one else could service those – that clientele. If you are the only – if you are one of the limited number of providers and you have increased volume, you can offer additional cost savings to Medicare.

In the rural area, though, that was not the case. No one was automatically kicked out of the market, so no one's volume went up. We're still servicing the same amount of volume, just at a lower price. So, the – whether you agree with the logic behind the

competitive bidding or not, that was one of the keystones of it, was that your volume would go up so you could offer a lower price.

The way that this impacts the Medicare beneficiaries in our area – we supply primary K0823 power wheelchair as well as complex rehab power wheelchairs. And when we get authorization for those – because Texas is a prior authorization state – we have 120 days from the date of the face to face in order to deliver that equipment. Prior to these cuts, we would deliver – we would get an approval today and we would be contacting the patient that day or the next day to schedule delivery as quickly as possible. Now, we – by necessity, we are unable to make a 200-mile roundtrip for a single delivery. We have to batch those. And so, instead of that Medicare beneficiary getting their equipment a day or two, you know, or as their schedule permitted, just immediate after the approval, they are now having to wait sometimes up to that full window of delivery for us to batch some deliveries together so that we can afford to go out and do that. I don't have to tell you the negative impact that that has on these people who desperately need the equipment.

The second impact that it truly has on the beneficiary is it completely eliminates any ability for them to have any choice in the equipment that they get. As someone earlier on the call alluded to, we're small suppliers. We don't have the buying power that the large CBA winners have. And so, for us, if you need a K0823 power chair, you get one of two models, and it essentially boils down to really about how tall you are because one of them has a little bit more adjustability than the other. And so, we hope that you like one of those two chairs because those are your only options.

Prior to these cuts, we were able to offer patients a much broader range of product that maybe they were just more comfortable with. Power wheelchairs come in rear-wheel drive, mid-wheel drive, and front-wheel drive. All of them handle just a little bit differently. And especially for someone who has been in a power chair in the past, they get used to how that machine operates. Unfortunately, we can no longer afford to provide the rear-wheel or the mid-wheel drive chairs. For whatever reason, they tend to be a little bit more expensive than the front-wheel drive. And so, our patients no longer have the option of choosing what type of chair they want or what is really something that is a convenience issue in the eyes of Medicare. They get a choice of one or two models. And that breaks down to, basically, how tall you are.

So, these prices were implemented for a area where the bid winners would see highly increased volume so they could give Medicare much reduced pricing. In the rural areas, we do not see that increase in volume. So, we as the – we're the only power wheelchair with a physical presence in this 60- to 100-mile radius from Bryan, Texas. And we simply do not have the advantage of – you know, if we had doubled our volume or quadrupled our volume the day that the prices went down, we would not be in near the world of hurt that we are today. But the fact of the matter is that our volume stayed the same, but our prices were cut over in half. We're down about 54, 55 percent.

So I appreciate you taking our comments, and have a good afternoon.

Leah Nguyen: Thank you.

Operator: And our next comment will come from the line of Timothy Scanlon.

Timothy Scanlon: Good afternoon and thank you. I certainly want to echo the sentiments of Rebecca in what we're struggling with. I'm with Franciscan Health Support in upstate New York, Syracuse. The ZIP Code is 13088. I operate both in a competitive bid area with a contract and I also operate branches in the rural upstate New York area and the southern tier.

These cuts have been dramatic for us. We find ourselves in a position where we're unable to service the Medicare beneficiary. And it's really a travesty what the competitive bidding program has done. If you look at claims for walkers and mobility products, they're down 30, 40 percent CMS. But if you look at falls and fractures, they're skyrocketing. So saving money on a walker or a crutch or a cane or a commode is not how you're going to save health care dollars. And it's by providing safe solutions for our patients in their home.

And CMS is really struggling in trying to cut the reimbursement from the DME provider, and the DME provider is no longer able to provide the service. They're simply not going to be able to accept assignment, and those patients will not have the access to the durable medical equipment that they so need to stay home and they so deserve. And it's a classic case of being penny wise and pound foolish because inpatients' lengths of stays are being impacted, and readmissions to the hospitals are certainly being impacted. To save what—$75?

I appreciate your time. Thank you.

Operator: Our next feedback will come from the line of Joe Cammack.

Joe Cammack: Yes. Hello. This is Joe Cammack, Port Angeles, Washington, 98362. Jim's Pharmacy is our business. And our service area stretches from the Pacific Ocean to the west about 60 or 70 miles and all the way to Port Townsend, Washington, on the Puget Sound Coast. And our population density is an average of 42 people per square mile up here. So, the delivery zone, it's – you know, it's almost 2 hour to Neah Bay to deliver equipment there. It's an hour and a half to Forks, Washington, to deliver equipment there, and going in the opposite direction to Port Townsend our drive is anywhere from a half hour to an hour. So, driving time – you know, on your three factors to consider, our drive time is certainly substantial.

I guess – and the biggest factor is, again, the volume. And several people have reiterated or have stated that before. But, you know, there's no way that we as a small provider can provide service at the same expense because we simply have to pay more for product. There's no way that we can dispense, you know, 400 oxygen concentrators in our area because there aren't that many people who require oxygen, even if we were the sole provider.

So to me it is extremely unrealistic for Medicare to make a 50-percent-plus cut and expect us just to absorb that. I cannot think of any other single business that I have ever been associated with where we would go in and say, Well, guess what? You're going to make 50 percent less, but we expect you to continue to function. And I – again, I don't know – I know that there's a statute that indicates that there is supposed to have been a study done on this. And, boy, how I'd really like to see that because, you know, to expect us to take an over 50-percent cut on our major items is unrealistic.

And the results of that have been – you know, have been devastating. I mean, you know, not only to us as a business but, more importantly, to beneficiaries. You know, I simply cannot give out equipment to a beneficiary losing money. And, so, we tell those beneficiaries that we're going to bill this – you know, be billed on assignment. And many of those beneficiaries, after they hear that news, turn around and walk out without the item and, consequently, end up, you know, having further issues.

And what's really ironic about this is that, you know, we run a pharmacy as well as a DME business all in one building. In the pharmacy business, at least that side has been smart because the biggest word in the pharmacy business is adherence. Because in the pharmacy business, they understand that if you don't take the medication to treat your particular disease state, you're going to end up back in the hospital with that same disease state, costing the system more money. So it is extremely ironic to me that on the DME side that they have the attitude of, Well, if they come in and they can't get it, well then they'll just learn to live without it. I mean, you, in essence, are forcing non-adherence, which is totally counterintuitive to the pharmacy side of business. And I really just – as a medical provider, I can't even grasp where it is that that makes sense.

So, you know, and as the other people have said, you know, a) the Cures Act needs to be implemented much faster. You know, the care – when you come back to us and ask for a refund back because of something that was mis-billed or whatever, boom, you take it right now. Yet, the Cures Act was, you know, passed in, you know, December of 2016, and you're expecting us to wait 6, 7, or 8 months to get the reimbursement for that. Again, not fair at all.

I know I also questioned one of the CMS employees in the Seattle office. And I asked her specifically, you know, Are you going to notify Medicare beneficiaries of the Cures Act change and the fact that they may be responsible for additional charges as a result of this? Because many people don't have a secondary to pay for the other 20 percent. And her answer was, Well, you know, I don't know and I'm not sure that that's our job. We as providers are required to give to the patient notifications of almost everything – notifications of items that's going to be covered, notification of their rights, etc., etc., etc. Why is it that CMS is not held to that same standard? Again, it just – it doesn't seem right.

And, lastly, we need to get this fixed, and we need to get rates adjusted retroactively back to January 1st of 2017 and fix this going forward and not wait until 2019. Because, quite frankly, we won't be in the DME business in 2019. As a department, our DME department, by the time you include cost of goods and labor only—not allocating any other expenses—is losing money.

And, you know, I'm not going to continue to let the ship leak and, you know, watch it go down as a result of sitting around and waiting. You know, that doesn't make good

business sense because then I've lost my entire business as a result of the DME section. That's all I have to say. Thank you.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Lisa Prentice.

Lisa Prentice: Hi. I'm Lisa Prentice. I'm from Assist Home Care in central Pennsylvania. We're a durable medical equipment provider that dispenses everything from canes and crutches to beds, oxygen, CPAPs, and that. And my concern is, you know, in considering the reimbursement, not only the service of the patient, which, unfortunately, is suffering due to the reimbursement cuts due to being able to reimburse, you know, our respiratory therapists and, you know, manpower from all the cuts, but also the quality of the equipment, which was alluded to by other callers as well.

I would like you to take that into consideration because, not only does the buying power of a big provider needs to be taken into effect and account, but also the quality of the equipment that you're purchasing. You can be a small provider and provide good quality equipment that you know that you, your family, and your patients can count on that's going to benefit your patients and be worthy of dispensing to a beneficiary meeting all the criteria and guidelines that are held by the Federal Government and that.

But some of the providers, in order to be able to make ends meet and pay their employees and all the fees and regulations and everything in order to remain in business and keep their heads above water, have been forced to look at items that – they may not be their first choice in purchasing for their beneficiaries – the Medicare beneficiaries. And the reason they're forced to do this is because of the reimbursement cuts. You see that there is a walker or a bed or, you know, other items that, obviously, there's different manufacturers, and depending on what manufacturer and vendor you go through, you know, they're, you know, vying for your business, so they're giving you different prices. Well, obviously, it's kind of like a car. You get what you pay for.

And with our business – we're a family business, and we pride ourselves in the fact that we try to do everything, you know, American made that we can, which is tough in today's economy and also is going to be durable. It's going to last the beneficiary, it's going to be something that we pride ourselves in dispensing. And we've taken over the course of the past year significant hits. And in order to try to maintain purchasing that

equipment for the beneficiary, giving them the quality that they deserve is very difficult. We have, fortunately, been able to eat the cost. We've been fortunate enough to, as a small provider, to eat that. We, you know, still try purchase the same thing we did before the competitive bidding cuts went into effect.

What does that mean? Well, you know, I – as a family and my employees, we've not given raises. We've – or, actually, if you look at the monetary value, we're making less than what we did before all this went into effect. And is that how we really want to run our health care, where we are going and penalizing the industry as a whole for trying to take care of its people who have worked their entire lives? They have put into the Medicare, you know, through working and so forth and now it is their time that they need assistance and they have to get sub-average or even average equipment? They should be able to get top-of-the-line and get the service that they deserve and that we would want for ourselves. And I believe we need to look at that in the reimbursement calculation.

Thank you. Again, my name is Lisa Prentice from Assist Home Care. The ZIP Code is 17872.

Leah Nguyen: Thank you.

Comments from Suppliers Serving Non-Contiguous Areas

And we're now going to move on to our next segment. We would now like to hear from suppliers serving the non-contiguous areas.

Operator: To provide feedback, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please hold while we compile the roster.

Our first comment comes from the line of Ben Griffin.

Ben Griffin: Yes, this is Ben Griffin. I'm not sure I punched in the right area. But nevertheless, I'm with Griffin Medical Services out of ZIP Code 30720, which is Dalton, Georgia – northwest Georgia, east Tennessee. I certainly concur with what everyone has said. This thing is beyond belief unsustainable, not just in us staying in business but to provide adequate and good care for our seniors, which we've – I've been doing for 30 years.

We are primarily a respiratory company – oxygen, CPAP and IPAP, nocturnal ventilation, and apnea monitors for infants. These services are just not really provided from anywhere else. It's the only place the respiratory therapist can actually have an impact in patient care. All of these things that we're talking about here that we do and all these other folks do impact people's quality of life, as well as readmissions, all of which affect the bottom line at Medicare and other payer sources. We are the ones who provide the equipment to provide them a decent home life not even taking into account that safety and all the other things that limit falls and such as that. And these reimbursement rates are just beyond belief. We couldn't sell hotdogs and make a living at these comparable rates.

We just ask CMS to be cognizant of this, and to please freeze these rates, go into these oxygen formulas and find some sanity in your reimbursement and accelerate this Cures Act reimbursement as soon as possible so that we can get some relief from that while these other decisions are made. We just need some adults in the room here.

I appreciate your time and taking the opportunity to listen to us. And, again, it's Ben Griffin, 30720. Thank you.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Douglas Coleman.

Douglas Coleman: Thank you. Douglas Coleman representing Major Medical Supply and the Colorado Association for Medical Equipment Services, ZIP Code 80538.

My comments are really the doubling and tripling down of pricing set by a flawed system to rural areas is extremely flawed and unsustainable. The – CMS has not followed and implemented rules in the initial rounds, so prices set by the initial competitive bid rounds are flawed. There were some providers who won bids for all or nearly all contracts and all MSAs out of a single location or one or two locations. There's no possible way that those kind of providers would have met financial standards to simultaneously open locations to service 100-plus MSAs. It so stated that the providers had to be ready to service their contracts day 1 of the contract.

In representing Colorado, there are over half of the bid winners of the initial and subsequent round two recompete. Over half of those providers do not have locations in

our area and are not servicing the contracts. And so, obviously, they're not ready day 1 of the contract and should be eliminated.

Providers also were supposed to submit bids that are non-binding. And CMS did not remove bid rates or did not adjust bid rates when providers refused contracts. And, again, in Colorado, a number of suppliers have set up sham locations, and we are working with investigators from our State to get them removed from the program.

Coincidentally, while I was sitting and listening to some earlier testimony on this call, I received a text from somebody who was looking to sell their business, that Lincare, which is a large national supplier, as you may know, just closed their office in one of the rural areas and wanting to know if that would impact our ability to buy their company. We continue to see people leaving and exiting the space already, and it's only going to get worse, and rural customers will not receive any options or any care, which is going to increase the cost of the program. It seems insane that there is siloing that the CMS program for DME doesn't impact at all or have any concern what we can do to save costs in other more expensive care settings, especially hospitals, nursing homes, and, again, other more expensive care settings.

So, I appreciate the opportunity to contribute. Again, Douglas Coleman, Major Medical Supply, 80538.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Randy Lutz.

Randy Lutz: Good afternoon. My name is Randy Lutz, and I'm from ThedaCare At Home in Appleton, Wisconsin, 54956. Our organization is a part of an integrated health care delivery system servicing 15 counties in northeast Wisconsin. Our services cover a 100-mile radius from our home office. We are a full-service DME, respiratory, home care, hospice company. We are currently in a non-bid area. Competitive bidding has not only impacted our DME and respiratory part of our business, but has also impacted our home care, hospice, and our hospital parts of our organization.

From a cost perspective, we are finding that our hospital readmissions have gone up. Our delays in being able to service our customers being discharged from the hospitals have increased, which is creating a greater length of stay in our hospitals. We are also

scaling back on the volume and the number of services that we do provide to our customers in our service area, which, ultimately, has impacted the consumers of durable medical equipment. Our costs have substantially gone up related to being able to service the customer at a lower margin, and we continue to decline in our margins, and it has created quite an impact on our overall business.

We are hoping that CMS will listen to all of the individuals on the call today and take consideration of how the rural and competitive bidding program continues in the future, because the way it is set up currently today is unsustainable.

Thank you, and I appreciate your time.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Jason Morin.

Jason Morin: Hi. Thank you for taking my call. I work for an organization called Home Care Specialists. We have four branches in Maine, New Hampshire, and Massachusetts, and we currently cover two competitive bid areas as well as rural areas in Maine and New Hampshire.

So I just wanted to, first of all, echo pretty much everything that I've heard so far on the call, but also weigh in as a provider who does have a lot of economies of scale and volume purchasing that some of the other providers have alluded to. And I can say with all certainty that those economies of scale don't translate into an ability to effectively service these rural areas at these rates. It's just not sustainable. So what we're seeing is more of a cost shift to the patients as more and more providers are billing unassigned or just saying no and the patients are having to go out and purchase this item out of pocket.

Another comment that I'd like to make is regarding the responsibility of CMS in these rate settings. CMS sets the bar for so many of the other payers in our industry, whether they be larger national payers or more regional payers. And what we're seeing is that this flawed methodology has created unsustainably low rates, and now more and more payers are jumping on board following these blindly and lowering their fee schedules to the point that it puts our entire industry at risk.

So that's all I have to say from me. I'd also like to weigh in as the current chairman of the HOMES Association – Home Medical Equipment Suppliers of New England. We are hearing from pretty much all of our rural providers how these rates are just completely unsustainable and are daily faced with new challenged of just how to keep their operations going and keep their businesses afloat. I strongly urge CMS to reconsider and rethink this methodology.

Thank you for your time.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Greg Dunn.

Greg Dunn: Yes. I work for Alpine Home Medical and we have offices throughout the state of Utah, with some being in competitive bid areas, Salt Lake City, and then others being in rural areas like Price, Utah, and Richfield, Utah.

And we are losing money on just about every item we provide that's Medicare with this new fee schedule, whether you're in a competitive bid area or not in a competitive bid area. And a business losing money can't survive and things have to change. So we, like many others, are now billing many things non-assigned. And as previous callers have stated, patients are either having to pay out of pocket for it or they're having to go find it somewhere else, or they're just going without.

And we're further impacted by – there's a lot of commercial payers that we're are all contracted with that follow Medicare's fee schedule and go off of the discount, so – of the fee schedule. So we find that we are losing money on some of those payers as well. So, it's the same thing that's happening. And we've encouraged many of our rural offices to narrow their bandwidth and not cover some of the more rural areas because we just can't afford to do so.

So, another thing that happens that's not being noticed necessarily as a part of the program is the fact that, you know, in the hospital setting and with the enforcement of the chronic stable state testing coverage criteria on inpatient discharges, the majority of patients we find out of the hospital anymore do not qualify for oxygen. And so, they're required to sign an ABN and make payment. Many of these patients are on a fixed income and they refuse. With the lack of the equipment that they need to recover in the

home setting, some end up longer in the hospital or they end up risking readmission. In the past, if a patient qualified for a financial hardship, we could work with those patients with previous fee schedules. But with where these competitive bid rates are now, we're unable to provide the equipment to many of these patients, and they go with risking their health or possible readmissions. So I'm sure hoping that we can bring some common sense back to this durable medical equipment situation.

Leah Nguyen: Yes, thank you. Could we get the name of your company and your ZIP Code?

Greg Dunn: Alpine Home Medical, 84107.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Audrey Jantzen.

Larry Jantzen: Yes, hi. This is Larry Jantzen. Audrey is my wife. We own Larry's Home Oxygen in Oklahoma. The ZIP Code is 73701. And I do agree with the previous callers. They made some very good points. Here at – we're in a rural area. We cover about an 80-mile radius in any direction. Some of that area is in bid area, but we do not – we just – we didn't get a bid. So, we're not doing that. We just have to do private pay if somebody wants to come up here and buy something.

We have noticed a – over 60-percent, anywhere from 60-percent to 70-percent cut in oxygen reimbursement from 2006. So, you know, we're down to $70 or $80, I'm sure, by no surprises, a month now for 3 years, 2 years provided at next to nothing. So, there's just no way a business can do that. We do handle oxygen, CPAP, pretty much full-line DME. We have power chairs, scooters, which…. We – the only items we really accept Medicare on right now is oxygen, CPAP, and BiPAP, which – I don't know how long we'll be doing that. And we've – we're one of the only companies in this area that had been setting Medicare patients up after hours or on weekends coming out of the hospital or anywhere for that matter. But – and I'm not sure that we can do that anymore.

We've had to go to shifting most of the financial responsibility on to the patients. And the problem with doing non-assigned on so much of the small stuff like four wheel walkers with seats and hand brakes, is that if Medicare comes back and wants to audit

that—shoot, for $140 or whatever it is, we can't afford to touch that claim again after we've once gather all the paperwork, billed it and everything else, and then you want to come back and audit it. And if you – the way I understand it, if you audit it and if it's denied, you want the money back from us, and then we're sitting here without the money and without the item, and we've done all the work and it's just all gone. It's not like – and some – you know, that could be – the patient could be dead by the time you do this. And, so, there's nobody to go back on. It's just not a workable system.

And we are – we're a private business. So – and a lot of these private businesses are closing in this area. There's very few left. I think, overall, what you're going to end up with if you continue this is a few – a handful of few national companies doing everything, all your Medicare oxygen and CPAP business. Then they're going to come back to CMS and say, Listen, it's not sustainable. Either we're going to dump all these patients back to you or you're going to have to raise your rates.

So, you know, the Cures Act is not even going to really fix the situation for a business to have a margin. A business has to have a margin to stay in business. So, when we're a private business like this, if we don't have a margin, we're not going to stay in business. So CMS has got to understand this, and they've got to come out in the real world and look at this. You know, if they'd like to come to our location, we'd be glad to walk them through what it takes to actually discharge a patient from a hospital and set them up on Medicare oxygen. It's almost an impossibility because the doctors usually aren't there anymore by the time the outpatient planners call us for the discharge and none of them want to do the discharge and they don't – have a hard time printing out the electronic signature. It's just an on and on battle on that. So, you know, I think this is an unsustainable system. We're trying to more private than insurance because it's just not affordable. I appreciate your time. Thank you.

Leah Nguyen: Thank you.

Operator: And our next comment comes from the Al Neumann.

Al Neumann: Hi. My name is Al Neumann. We have Corner Home Medical here in Minnesota. We have 11 locations. We are in a competitive bid area, but we service the entire State, northern Iowa, western Wisconsin. We have the VA contract.

What CMS has done is taken the delivery out of Medicare. The VA recognizes – and it doesn't matter what we deliver. We have a fixed delivery fee, and we're paid mileage outside of our normal service areas. So, again, I thank everybody for their comments. But – and we're large. We have a very large footprint in Minnesota. We can't afford to do Medicare. So, who suffers? It's all the people that we take care of.

And so, I thank you for your time. Just saying, we're probably going to non-assigned throughout the state of Minnesota. Thank you.

Leah Nguyen: Thank you. Could we get your ZIP Code?

Al Neumann: 55427.

Leah Nguyen: Thank you.

Operator: And no further comments at this time.

Comments from All Other Suppliers

Leah Nguyen: Thank you. We're going to move on to segment three. We would now like to hear from all other suppliers.

Operator: To provide your feedback, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key.

And our first comment will come from the line of Diana Escalera.

Diana Escalera: Hi, everybody. We really want to reiterate a lot of what we heard today. We agree with a lot of what we're hearing. I'm with Academy Medical Equipment. We service Las Vegas, Nevada, and central and southern California. Our ZIP Codes are 89128, 92126, 93711, 90242, and 91761. We primarily provide complex rehab power wheelchairs and also service and repair for all power mobility.

We'd really like the – to see the bid rates versus the cost of equipment to be evaluated. Reimbursement has gone down significantly whereas the cost of the equipment has either remained the same or actually gone up. What we have found is that the competitive bid winners frequently underbid on parts and accessories in order to win the bid for the new chair sales. We've even tried to refer repairs to competitive bid

winners in our areas, and they have been turned away. We've called those providers directly, and we have been told, We will not service or repair any equipment unless we sold that equipment. And they have stated to us that, yes, they did intentionally bid low on the parts and accessories because they wanted to win the bid for the new sales.

The cost, for example, on parts on batteries, as an example, for us is $5 more than reimbursement. So, every time we provide batteries as a repair to a patient, we've lost $5 right off the bat, not to mention the time – the administrative time and the drive time involved in that. We have had to require that our patients pay cash and we bill unassigned. Most of our patients cannot afford that. And as a result, they are not getting the service. We have provided our patients with the numbers to call CMS, to call their legislators and, Joel, sorry, we've provided your information as well. When they call 1-800-MEDICARE, they are basically put on an indefinite hold. There's no way to leave a voice message. So, they really – even though there's a number, they have no way to communicate to Medicare that they're not getting the service that they need on their equipment.

Another thing that we've seen with the competitive bid winners in our area is patients who are complex and need complex equipment are being referred to those providers because they won the bid, and they're being put in inappropriate equipment. Then, within the 5-year period that's supposed to be the lifetime of the equipment, they do end up coming to us down the road and we're seeing wounds and we're seeing progression in their equipment or in their diagnosis or in their ...

Female on the participant line: Posture.

Diana Escalera: Yes. We're seeing postural asymmetries. And we are then providing them with the appropriate equipment to accommodate their conditions. So, now, Medicare has paid for two pieces of equipment in less than 5 years, which is a huge waste to the Medicare program.

Speaking of the complex rehab versus the standard equipment, another huge area of concern is the fact that the accessories and repair parts do not have different codes for the different type of equipment. Motors is a perfect example of this. It's the same code. But a motor on a group two chair is significantly less expensive than a motor on a complex rehab chair. Same thing with the heavy duty. Even though it's a standard heavy

duty, the cost of a motor on that heavy-duty chair is significantly more expensive than just a standard.

The Cures Act did only extend the unadjusted fee schedule through June 30th of this year. We are very concerned about that because we will not be able to afford to provide complex rehab equipment after that time unless that gets changed. So we do want to focus on the fact that the complex rehab does need to be carved out. These high-level patients will not be serviced. They'll be bed-bound. It puts them at risk for ulcers. Their conditions will worsen. It will increase hospitalization and nursing facility admissions.

DME, in general, is intended to keep patients safe at home and out of hospitals and facilities. Reports from CMS have stated that there have not been an increase in hospitalization due to lack of access to equipment. However, through our own experience with our patients and in our personal lives, hospitals are not asking the question. You know, did you get this sore because your wheelchair was broken and you couldn't use your wheelchair? Or is your hip broken because you fell because you were trying to ambulate without your wheelchair or because your batteries were dead and you couldn't get them replaced? These types of questions aren't being asked. So we're wondering where the statistics are even coming from as far as meaning – as far as saying that those hospital visits and facility inpatient experiences aren't happening. What we request is…

Leah Nguyen: Thank you. We're going to move on to the next comment. But you can press star, one to get back into the queue. Thank you.

Operator: Our next comment will come from the line of Kim Brummett.

Kim Brummett: **…**supplier. We represent many suppliers in the country. And I've listened to many of the comments today. And just in a simple poll for our users, we have found that 10 percent indicated a shrinking service area or not servicing patients at all, 15 percent indicated a reduction in products provided, and 18 percent in reduction in the number of providers in their area. Is CMS is going to be looking at and addressing some of these types of statistics?

Leah Nguyen: Thank you. We're not responding to questions today. But could we get your company name and ZIP Code?

Kim Brummett: Sure. It's the American Association for Homecare. Our ZIP Code is 22202.

Leah Nguyen: That's great.

Kim Brummett: And we will also be posing the question on what will happen post this call. I know it'll be turned into a transcript. But will we be seeing any type of rulemaking going forward as well?

Leah Nguyen: Thank you. We're not responding to questions. But thank you for your comment.

Operator: Our next comment will come from the line of Larry Dalton.

Larry Dalton: Good afternoon. I'm Larry Dalton with Advanced Care Medical Equipment, and I'm in southern Oklahoma. And we are covering an area of about 20 counties, which comes out to be about a population about 600,000 people, which is 19.3 percent of those are senior citizens. Our runs run about 100 to 110 miles out at the max. And we're trying to service these people in this rural area. Most of this area is country roads, is country lifestyle. There are all kinds of situations that we encounter in the environment, from the cattle being in the roads and having to wait on them and so forth and – to muddy roads that we can't hardly get through. But through all that, we have the compassion to take care of our people here, and we're trying to service them the best we can. At the present rates of the oxygen, I cannot – even if they're in my backyard, I cannot be able to make any money off of it trying to do it in all different ways. And if you had taken care of patients for 5 years, it's total losing proposition. I have two patients now that are living in California and moved out there because -- kids – and I can't get anybody to take over the oxygen out there, and so I'm having to take care of that as well.

One of the things I'd like to share with you is I have a gentleman here that we met a few years ago. His name was Del. And I took him some equipment back a couple of years ago. And he had two bad knees, and I asked him then – I said, Why don't you get those knees repaired? You're 85 years old. And he said, Why in the world would I want to spend the Government's money on two brand new knees when I'm 85 years old? A few days ago, he was needing a bedside commode. He lives 38 miles from here. And my CSR was telling him that we cannot deliver that. And this is a guy – that I caught – thank God

I caught that conversation and I delivered it out of my own pocket to him. But this is a gentleman that served in the Korean War. He never used the Veterans at all. And he wanted to save the Government money, but the Government did not want to take him a bedside commode. That doesn't seem right to me. This country has changed, and it doesn't seem right.

And I – that is all I got to say. Thank you.

Leah Nguyen: Thank you.

Operator: Thank you. Our next comment will come from the line of Don Clayback.

Don Clayback: Hi. My name is Don Clayback. I'm with the National Coalition for Assistive and Rehab Technology. We are – we have 350 member locations across the country focused primarily on wheelchairs, sitting and positioning systems, and repairs. We'll be resubmitting our written comments, so in the interest of time, we won't go into a lot of detail. But we did want to share a couple of points.

One, we appreciate the call today. But hopefully this is the first step in terms of meeting the first bullet point under the 21st Century Cures Act and around requiring solicitation of stakeholder input. We kind of view that as a critical piece of the Cures Act.

The second part that talks about comparison of data points is equally important and, I think, how that data is going to be accumulated and also how the information relative to stakeholder input could be derived. I think the written comments that are due on April 6th is a good first step. But we would also encourage CMS to look at developing some sort of survey or working with some of the national supplier organizations and some of the national consumer groups that would really – and not get overly complicated but solicit some input, you know, on things like the quality of the products, the timeliness of delivery, and the timeliness and quality of followup service.

Of particular concern to us and our members is wheelchair repairs. And one of the other callers mentioned that. But that's already an area that was really under duress because of the low payment rates and the lack of compensation for much of the time that a supplier spends on repairing the wheelchair. And that has just been driven – it's even at worse stage based on now the lower competitive bidding rates.

So, as I said, I think our question is, after the written comments are received, what else will be done to engage stakeholders because maybe the good news is CMS has time to solicit this information. I feel comfortable saying the stakeholders are ready, willing, and able to supply that. So, hopefully, there'll be some additional things such as a survey post the written comments. Thank you.

Leah Nguyen: Thank you.

Operator: Our next comment comes from the line of Keith Howell.

Keith Howell: My name's Keith Howell. I'm with Pleasant Valley Home Medical Equipment in West Virginia. We're right on the West Virginia and Ohio border. I agree with all of the comments that everybody said. And it's been kind of interesting to hear that it's across the nation. So I think this is real concern. We're in the same boat everybody else is. We're a DME company. We're full service. We've actually had to stop doing beds and wheelchairs through Medicare because the reimbursement – we can't put one out for the cost of the reimbursement.

Over the payment schedule, by the time we get done, we're not making any money if we even get paid for and if it doesn't go into audit for paperwork or whatever reason. So we are definitely in a rural area here. Our clients are all on fixed incomes. It's actually hurt our business by not being able to do that service for them because they're going to other companies that can still stay in that. But with being a smaller organization, we can't get the pricing.

So, I definitely agree with everything everybody said, and it definitely needs to be fixed at this point. And if it waits too much longer, we're kind of in the same boat, we may not be here. So, it is a very serious thing and I think that it needs to be taken care of as fast as possible.

And, again, my name's Keith Howell with Pleasant Valley Home Medical Equipment. Our ZIP Code is 25550. Thank you.

Leah Nguyen: Thank you.

Operator: Thank you. Your next comment comes from the line of Dave McCausland.

Dave McCausland: Yes. Hello. Can you hear me?

Leah Nguyen: Yes, we can.

Dave McCausland: Okay. Great. Thank you so much for your time. This is Dave McCausland. I work now part time for Permobil, but I semi-retired about 6 months ago. And I had three comments that I wanted to bring up. I know you're not going to be responding to any questions.

So – but, in general, my first comment – we do have the opportunity to provide you with additional input prior to April 6th. That having been said, I would strongly encourage you to provide some additional clarification on the three points that you're investigating so that we can make sure and give you the best comments we possibly can, specifically any additional detail you can provide on the second point, the average volume of items and services furnished by suppliers in the area. Any additional information there, I think, would only, you know, pay you back dividends by giving you better information. So I hope you will look at providing some clarification before the 6th.

The second thing that I wanted to comment on—in my over 30 years of doing DME both as a provider and as a manufacturer – I actually worked as the general manager for a national firm years ago covering the state of Oklahoma. And this was prior to competitive bidding or many of the things that we now deal with. And even then it was next to impossible for us to keep rural branches open, especially for some of your standard capital DME, things like hospital beds and wheelchairs. And this was before competitive bidding. This was back before the inordinate amount of additional documentation that's now required to really qualify the person up front, let alone the cost of delivery, which in the rural areas can be, you know, 40 to 50 miles one way, if not more, not to mention that you have 13 months' worth of capital billing times to payers, you know, always being prepared for subsequent review. You know, years ago, it was difficult. I cannot imagine how anyone can stay open in the rural areas with the structure and the labor that's required today.

And, then, the last comment, to reiterate something I heard earlier, in my semi-retirement, I have become more actively involved in a not-for-profit in the St. Louis metropolitan area. And I can tell you one of the things that we are seeing that's becoming very, very difficult – we are having a terrible time at trying to provide – trying

to identify providers that are willing to address the repairs on equipment, especially high-end power wheelchairs over an extended period of time. So, you know, I really hope that CMS will consider all of this and will take this into consideration, will address the needs of the rural area, but more importantly, address the needs of the end users to make sure that their products are accessible and maintained during the period.

Thank you.

Leah Nguyen: Thank you. Could we get your ZIP Code, please?

Dave McCausland: Yes. My ZIP is 62034.

Leah Nguyen: Great. Thank you.

Operator: Thank you. Your next comment will come from the line of Laura Cohen.

Laura Cohen: Hello. My name is Laura Cohen, and I am the executive director for the Clinician Task Force. I represent a group – a national group of physical and occupational therapists that provide services – clinical services. I wanted to agree with a lot of the comments – all of the comments that I've heard today. One of the things that I – that our group encounters regularly is many of the CMS policies require a specialty evaluation to make recommendations for the equipment that's needed. Yet, when it comes down to it, we're not able to get that person what they need due to limited options that are out there for – by the contracted competitive bid winners.

There were some comments there that implied that they were only able to provide one or two options to a Medicare beneficiary, whereas before there were many other options available. What I want to emphasize is, many times, because of an antiquated HCPCS coding system, there are dissimilar products grouped together in the same code. And as a result, there are specific functionalities within a code that are not represented by the one or two options that are available. So the patient isn't actually getting the product that has the functions that they require to meet their medical needs. And that's not adequately being picked up in the data that you're collecting.

And, so, when you're talking about the three factors that you're collecting data on, I would strongly recommend adding something that can grab hold of the data about the make and the model of the products being provided. Initially, when competitive bidding

was implemented, the bidders had to provide information about what makes and models they were going to be able to provide. But there's been no enforcement of that. And, you know, there's a big difference as far as mobility and accessibility between a mid-wheel, rear-wheel, and front-wheel drive power wheelchair. But if the only option is to get a mid-wheel, you're creating function and access problems for the people who can't get what they truly need.

And, what else? The other issue is when a beneficiary can't get what they need, they are referred to the CMS line. And when they get on that line, if they actually are successful in getting a human—which, many times, they're not—they're merely given a phone number or a list of the bid winners. But that doesn't solve the problem because they still are not able to access the equipment that they should be able to access that is within the code and that is medically necessary for them. And I support the earlier comments that there's opportunity to gather more granular-level data that will help further define the consumer access issues through this effort.

Thank you.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Terry Racciato. Terry, if you're on mute, please unmute your line. If you're on a speakerphone, please pick up your handset.

That question has been withdrawn.

Your next question will come from the line of John Curelli.

John Curelli: Thank you. This is John Corelli. My son and I are the sole providers of oxygen, PAP, and DME for the island of Martha's Vineyard about 7 miles off the coast of Massachusetts, essentially a very isolated, rural location. Our year-round population is about 15 to 16,000. Because we're a highly touristed area, in the summer we consequently have a large population of service economy workers who are paid low wages, many immigrants that work on visa programs that have no or poor insurance, which we need to service as a sole provider.

I wanted to say that when I started the business in 1974 until this past January, we have always been a participating provider. And after much handwringing and discussion with patients and customers and the hospital here, I've had to switch to non-participating and bill Medicare patients as non-assigned.

And like most rural providers, our customers and patients are our neighbors, our friends and relatives, and multi-generations of the same family. And it's really hard to look at them in the eye in the post office or the market when they say they can't afford to pay for this piece of equipment even after Medicare pays their 80 percent to them. And it's just ironical – the irony of this all is that before patients even warm a hospital bed, plans for their discharge to a more appropriate setting in their home are taking place. And we get the call and are able to provide services and equipment within hours at most of discharge, and to the benefit of the insurance companies and Medicare at a lower cost in providing the needs for family and caregivers of patients, particularly those which we serve for a number of hospice patients on the island.

We've prided ourselves for the last 43 years of providing the most clinically appropriate, safest prescribed equipment for the patient. And, unfortunately, with our losses, we now have to look at the least expensive device or piece of equipment. Our volume does not allow manufacturer discounts that are given to large providers. The market efficiencies on an island are 20 to 30 percent higher than on the mainland. And if you can imagine a $70 toll booth on your local highway every time you needed to leave the island to get supplies or to service a piece of equipment to a manufacturer, for example, or $300 for a delivery truck to bring the inventories that we need to maintain in high levels because, many times, due to storms, we are isolated and need to provide 24/7 service for critically ill oxygen patients at home. That's not something that we take lightly as a responsibility.

We need to have relief. The Cures Act needs to help cure this industry. Unfortunately, the sole provider for the next island out, Nantucket, another 26 miles out, has pulled their services because of their lack of efficient profitable business. We had hoped 7 years ago with a 5-year plan to be able to open a branch there. But we can't with the economies of the new rates. We're hoping that we don't have to leave Martha's Vineyard Island without a DME and oxygen provider. It's just something that we have taken pride in serving with care and excellence of care to all our patients. And I know that all the other rural providers are trying to maintain the same level of care and

services. And we hope that the decisionmakers will look at DME not as a commodity to be dropped off by a UPS truck but as a service model of caring for a patient.

The responsibilities of our accreditation, my license as a registered respiratory therapist, requires that we provide an overall review of safety, clinical needs, and appropriateness in the patient's ability to learn to use equipment properly. That's more than just a drop off and a delivery. We deserve to be appropriately reimbursed, much more than the loss of 50 percent in our rates with a cost that's 20 to 30 percent higher on an island. I just filled up the truck with gasoline at $3.18 for regular. Diesel's about the same price. Our electric rates are the highest in New England. And, again, we have the ferry to deal with to add on freight charges for every shipment to us.

So, I appreciate the opportunity to voice our needs and our compelling needs to help patients as other rural providers do. And I look forward to submitting written comments as well. Again, my name is John Curelli. The business is Island Home Medical on Martha's Vineyard Island, ZIP Code 02557. Thank you.

Leah Nguyen: Thank you. We have time for one final comment.

Operator: And that comment will come from Eric Sorsen.

Eric Sorsen: Yes. Thank you for taking my call. First of all, I just want to say it's just really great to hear from everybody in the industry today and all of us kind of coming together despite the kind of collective suffering that we're all going under for our patients here. And, you know, I want to allude back to something that somebody brought up about – you know, a gentleman earlier mentioned about, you know, the study that was supposedly done that would show how it impacted business. I can tell you up here – I'm in Minnesota, I'm about 45 minutes west of Minneapolis. My ZIP Code is 55387. And we have a – we're a hospital-based system and, basically, you know, our main job is to help patients get out of the hospital and get home and get what they need to stay out of the hospital. But if it's a Medicare patient, you know, they are susceptible to being hung up and not being able to get out of the hospital with what they need.

One of the things about that that I would challenge for the survey about access is the contracted supplier in our area is a company from Puerto Rico. I'm not quite sure how they get a nebulizer in Minnesota, you know, to a patient in time to get out of a hospital without, you know, incurring more costs to the hospital to the, you know, to Medicare

in general. I see a lot of bigger companies buying up smaller companies, you know, just to get a hold of, you know, that nebulizer or that widget so that, you know, they can keep their, you know, hands involved with that patient until he, you know, gets into something profitable like non-invasive ventilation or something else in that fashion.

You know, and also with the CMS and all these policies, it is just feels like it's short-sighted policy after short-sighted policy, and they just build on one another and lead us further down a path from which I don't think anybody knows where to start, you know. And you have ALJ, you know, they're 4 or 5 years back. We just got a payment the other day from 4 years ago. It's just disappointing that, you know, CMS isn't held to the same standards that we are when it comes to documentation and response time and, you know, we're kind of kept in the dark as far as what to do.

You know, and I would just finish by saying, you know, does non-use of Medicare Part B equal cost savings? I mean, because that is what's happening. People just don't know where to go or they're not getting what they need and, yes, you can spend that and say you're saving billions and millions of dollars for Medicare, but in reality you're ruining people's lives.

So, thank you for your time.

Additional Information

Leah Nguyen: Thank you.

Unfortunately, that is all the time we have for today. If we did not have a chance – if you did not have a chance to give your feedback or would like to submit written comments, you can submit comments no later than April 6th, 2017. Please refer to slide 10 for the email address to submit your comment.

If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted on the MLN Connects Call website. We will place an announcement in the MLN Connects newsletter.

On slide 11 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your call experience.

Again, my name is Leah Nguyen. I would like to thank our presenters and thank you, our participants, for joining us for today's listening session on DMEPOS Adjusted Fee Schedule Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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