Legislative Update on H.R. 1845, 621 & 2231

Please urge your Congressional representative to cosponsor; talking points available.

VGM urges all HME providers to contact your Congressional representative's office in your district and ask for their support of these three bills.

Position papers follow below.

PLEASE COSPONSOR H.R. 621, THE HOME OXYGEN PATIENT PROTECTION ACT

VGM enthusiastically supports the Home Oxygen Patient Protection Act (HOPP Act), or H.R. 621, which was introduced by physician Congressman Tom Price (R-GA) on January 22nd, 2007. The HOPP Act may help a million oxygen patients to breathe easier by easing the burdens placed on them by the Deficit Reduction Act of 2005 (DRA).

Background

The HOPP Act would amend the Deficit Reduction Act by restoring Medicare treatment of ownership of oxygen equipment to the system that existed before the law was enacted. A provision in the DRA forces home oxygen patients to assume ownership of and responsibility for medical oxygen systems after 36 months of rental in Medicare.

That law effectively severs the patient provider relationship for home oxygen therapy under Medicare, which raises numerous patient safety issues. NEMED, The American Association for Homecare, the American Lung Association, and other patient and provider stakeholders vigorously opposed that change in Medicare policy.

Oxygen therapy is critical to approximately one million Americans who suffer from respiratory illnesses such as chronic obstructive pulmonary disease (COPD) and who require oxygen therapy under Medicare. Nationwide, as many as 15 million Americans have been diagnosed with COPD, a number that is growing. It is a slowly progressive, incurable disease that causes irreversible loss of lung function. Although existing medications have not proven beneficial in reversing its effects, home oxygen therapy—when properly prescribed and maintained—can slow or stop lung degeneration.

Medical oxygen is a federal legend drug and the devices are prescription only. Transferring the burden of ownership to the beneficiary presents serious risks to patient safety. Moreover, medical oxygen therapy at home costs an average of $7.62 per day in Medicare. A typical inpatient hospital day in Medicare costs $4,603. Oxygen therapy requires more than a piece of equipment. Service costs for medical oxygen therapy in the home exceed the cost of equipment by three to one: 72 percent of the costs required for providing home oxygen therapy are related to services and operation (intake, delivery,

maintenance, patient assessment and education, regulatory compliance, and other costs). The equipment represents just 28 percent of the costs of home oxygen therapy.

Please help Americans on oxygen therapy to breathe easier by signing on as a cosponsor. To sign onto H.R. 621, contact Keagan Resler in Congressman Price's office at 202-225-4501.

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PLEASE COSPONSOR H.R. 1845 - THE MEDICARE DURABLE MEDICAL EQUIPMENT ACCESS ACT OF 2007

Representatives John Tanner (D-TN) and Dave Hobson (R-OH) introduced in the House of Representatives on March 29, 2007, a new version of the "Medicare Durable Medical Equipment Access Act" which would make significant changes to the Medicare Modernization Act's provisions on competitive bidding for durable medical equipment. This bill would accomplish the following objectives: (1) Rationalize CMS' implementation of competitive acquisition for DMEPOS; (2) Ensure beneficiary access to quality items; and (3) Minimize small business closures from competitive acquisition.

Summary: H.R. 1845 "Medicare Durable Medical Equipment Access Act of 2007"
Beneficiary Protections

1. Quality Standards – Would require CMS to implement quality standards with the competitive bidding program. That is, all winning bidders would have to meet applicable Medicare quality standards. In addition, CMS would have to apply those standards to providers in and out of the bid areas.

2. Exempt Rural Areas – Would prohibit CMS from implementing competitive bidding in rural areas, defined as metropolitan statistical areas (MSAs) with fewer than 500,000 people.

3. Apply FACA to PAOC – Would apply provisions of the Federal Advisory Committee Act (FACA) to the Program Advisory and Oversight Committee (PAOC).

Qualified and Small Supplier Protections

1. Qualified Supplier Participation – Would allow any Medicare part B supplier that meets the quality standards and submits a bid for an item or service (below the current allowable) to provide those items and services at the final bid rate.

2. Restore Due Process – Would allow for administrative or judicial review under the Social Security Act, consistent with generally available appeal rights of affected parties under the Medicare Program. (The MMA eliminated any and all appeal rights of all affected parties.)

3. Define Significant Savings – Would define the term “significant savings” as ten percent, in the context of the provision that allows CMS to exempt items and services "not likely to result in significant savings." Would require CMS to first demonstrate the probability of achieving “significant savings” before a product or product category can be included in the bidding process.

4. Comparability Analysis – Would require CMS first to conduct a comparability analysis before implementing competitive bid rates in non-bid areas, effective January 1, 2009. The analysis must be published in the Federal Register and must include an analysis of the relative costs of providing the items and services in the respective geographic areas, and assess whether application of the bid rate in the non-bid area would adversely impact beneficiary access to quality items and services.

5. Report on Quality and Access Impacts of Initial 10 Sites – After CMS fully implements the initial 10 competitive bidding sites, HHS must conduct a complete analysis of the impact in those geographic areas on beneficiary access to quality products, impact on HME providers and services. That analysis must be completed before CMS could expand the program beyond the initial 10 sites.

6. Congress Must Re-Authorize Competitive Bidding After the Initial 10 Sites: The Secretary can not extend competitive bidding beyond the initial 10 sites or apply bid rates to non-bid areas, unless specifically authorized by Congress.

Please ensure patient choice, access to quality equipment, and protect small business by signing on to H.R. 1845.

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CONGRESS SHOULD PASS THE MEDICARE ACCESS TO COMPLEX REHABILITATION AND ASSISTIVE TECHNOLOGY ACT OF 2007

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a national competitive acquisition program for durable medical equipment. The program is scheduled to begin this year and will be phased in over several years. CMS has chosen to include complex rehab and assistive technology products in the first round of competitive bidding. Including complex rehab equipment in the competitive bidding program means that Medicare beneficiaries will be unable to obtain appropriate technology necessary to meet their functional and medical needs. The Medicare Access to Complex Rehabilitation and Assistive Technology Act of 2007 (H.R. 2231) would exempt complex rehab and assistive technology from the national competitive bidding program.

Position

Congress should pass the Medicare Access to Complex Rehabilitation and Assistive Technology Act of 2007 (H.R. 2231) so that Medicare beneficiaries will continue to have access to high quality products and services.

• Complex rehab technologies are not commodity products that are easily interchangeable. Each consumer of complex rehab technology has individual and specialized needs that require extensive customization.

• Competitive bidding fails to allow for the level of services and significant costs associated with the delivery of complex rehab technology to people with disabilities.

• Properly fitted equipment has a significant role not only in providing consumers with their greatest level of independence, but also in preventing or delaying related medical complications which can increase health care costs significantly.

• Significant savings will not be achieved by including complex rehab technology in competitive bidding. CMS has acknowledged that the complex rehab product category is "small". Data released by CMS demonstrates that utilization of complex rehab products is low. An industry commissioned study estimates the cost of the exemption over the first five years of the CB program to be $46 million.

Action Requested

Support the Medicare Access to Complex Rehabilitation and Assistive Technology Act of 2007 by signing on as a co-sponsor of the bill and urge the House leadership to support passage of this bill. Urge Senators to introduce companion legislation in the Senate.

To find your representative, go to http://capwiz.com/vgm/home/ and enter your zip code in the Elected Officials section.