

Issue, Government (House) Position - Industry Response

The Issue:

Members of the U.S. House of Representatives will vote on the budget reconciliation bill (S. 1932) when it returns to the House for a final vote about the first week of February.

Representative Bill Thomas inserted provisions within the bill that will hurt older Americans who depend on homecare medical equipment and services.

The bill eliminates older and disabled Americans' option to continue to rent home medical equipment, including critically important equipment used for oxygen therapy, under Medicare. Beneficiaries choose to rent rather than purchase this medical equipment because renting allows worry-free, professional maintenance of complex medical equipment and lowers costs to seniors. Forcing seniors to take title of complex medical equipment after a capped rental period is unfair and dangerous.

Oxygen equipment in particular is critical to approximately one million Americans who suffer from respiratory illnesses such as chronic obstructive pulmonary disease (COPD) and who require oxygen therapy. Oxygen is a federal legend drug and the devices are prescription only. Transferring the burden of maintenance and repair of sophisticated oxygen technologies to the beneficiary presents a serious risk to patient safety and care.

Bill Thomas also supports a new law that requires Medicare beneficiaries to be treated by a restricted group of providers that have been selected by the government due to their cut-rate services. This law will seriously compromise the quality of beneficiary care.

With regard to the Budget Bill, the Congressional staff has asserted:

This provision transfers ownership of oxygen equipment to the beneficiary after 36 months. Beneficiaries will now have more control over their oxygen needs, by allowing them to purchase after 36 months. However, this provision also ensures that all beneficiaries who rely on oxygen are covered.

Medicare currently pays around \$200 a month for renting oxygen equipment. On average Medicare beneficiaries use oxygen for 30 months, which means Medicare pays \$6,000 for a beneficiary. If a beneficiary needs oxygen for longer than 30 months this provision allows the beneficiary to rent for another 6 months. After 36 months, the beneficiary still receives monthly payments if they use a portable system that requires the delivery of oxygen. And if maintenance and servicing are required - Medicare will cover repairs and servicing as needed. However, the beneficiary is given more control to determine when servicing is necessary.

Congress needs to move towards a better payment system that protects our beneficiaries and the integrity of our Medicare program.

The Homecare Industry Response:

Oxygen patients have not asked for any more "control" over their equipment. Long-term oxygen patients cannot walk to their mailboxes without becoming breathless, let alone handle a lot of extra responsibility for maintaining medical equipment they don't understand. Long-term oxygen users are generally very satisfied with their homecare providers as measured by patient satisfaction surveys.

Beneficiaries do not know "when servicing is necessary." Many cannot follow a manufacturer's warranty or recommended maintenance schedule. They have no exposure to product recalls mandated by the FDA and would not know how to comply with a recall if needed. Oxygen is an FDA-regulated drug produced from FDA-regulated medical devices. Homecare providers ensure

that they are maintained regularly. Does Congress really want to put humans at risk of death or re-hospitalization due to low oxygen drug saturation levels?

Contrary to some Congressional staffers' beliefs, homecare providers WILL NOT buy used oxygen equipment back from beneficiaries. Most do not even buy used equipment from qualified equipment brokers today; they buy new to take care of patients. Patients will not maintain proof of maintenance, cleaning, service or recall management, and providers will not be willing to risk future Medicare oxygen patients' health by purchasing such equipment. Patients cannot "donate" the equipment back to for-profit entities either. This is a misguided assumption.

Medicare Part B premiums are rising largely due to an increase in physician office visits and related costs, not higher homecare costs. Attributing higher Medicare premiums to homecare is a fallacy. Homecare remains the most cost-effective treatment option for chronically ill patients.

Today, oxygen patients who learn about new oxygen technology such as Homefill and portable devices call their homecare provider to learn more about it and see if it meets their clinical and quality of life needs. Once the new provision goes into effect, any beneficiary with purchased oxygen equipment will have zero access to new technologies since it is likely that the Medicare program will only "buy" one concentrator per a certain time period, which is how nebulizers and CPAPs are handled today. This will cause great beneficiary dissatisfaction, and the provider will be in the middle.

While the average length of stay for Medicare oxygen patients may be 30 months, there are thousands of patients who last five or more years on oxygen. How will their clinical needs, equipment maintenance/servicing and other needs be met as their COPD worsens and they become incapacitated at home in the last phase of their chronic, terminal illness? These are the very patients who need in-home visits by respiratory therapists and other intervention. With zero reimbursement today for an in-home visit by a respiratory therapist, how would providers support such a request from the patient?

Medicare does not pay \$6000 for equipment alone. Even the proposed quality standards for competitive bidding for oxygen, developed by CMS consultants, explicitly acknowledge that an array of support services must be available and provided to oxygen patients around the clock. These patients receive in-home deliveries of portable tanks -- sometimes twice a month -- as well as patient education, equipment maintenance/troubleshooting, equipment exchange at no charge, emergency and disaster assistance during natural and manmade disasters, extra supplies, 24/7 on-call services and the labor-intensive Medicare and secondary insurance billing on their behalf. It is grossly misleading to suggest that Medicare pays that amount for the equipment alone. Even past OIG reports on the subject have acknowledged that Medicare billing and administrative service costs are 30% higher than for either the VA or private sector.

Today most providers simply exchange faulty equipment -- they do not repair it in the home. Assumptions made about maintenance and service frequency are drawn from a faulty OIG survey on this subject, which looked at only a small portion of the total maintenance and service functions performed for beneficiaries, and discounted a great number of survey responses.

Medicare has not established a fair and equitable fee schedule for maintenance and repairs as of this date. No research has been performed to suggest that these services will continue to be available should the 36-month cap go forward.

America's landfills and flea markets will be full of used, unsanitary, unmaintained FDA medical devices. Is that what the Congress desires?

Most patients and caregivers want to return the equipment as soon as their loved one dies or they no longer need it. Today, the provider picks it up at almost any time of any day after a death in the home. How does Congress expect a frail Medicare beneficiary or caregiver to dispose of a heavy metal hospital bed or oxygen concentrator?