COUNCIL FOR QUALITY RESPIRATORY CARE

Medicare Home Respiratory Therapy Benefit in Non-Competitive Bidding and Rural Areas Remains At Risk

- **Medicare beneficiaries rely upon home respiratory therapies to treat Chronic Obstructive Pulmonary Disease (COPD) and Obstructive Sleep Apnea.**

  - Home respiratory therapy is a critical set of services and equipment that could result in substantial savings to the Medicare program by reducing time spent in emergency rooms and nursing homes.

  - Home respiratory therapy suppliers can provide patient-centered services to reduce hospitalizations. Working with hospitals and commercial payors, CQRC companies have developed and implemented programs to help reduce hospitalization and Medicare program expenditures. Managed care programs and commercial payers recognize the important role home respiratory therapy suppliers play in reducing overall health care spending.

  - However, as CMS data show, the reductions in hospitalizations experienced by COPD patients in the commercial market are not occurring in the Medicare population. We believe that is because home respiratory therapy rates have been inappropriately cut year-over-year, while the cost of complying with Medicare documentation requirements has substantially increased. These documentation related costs can be 40 percent or more of the cost of caring for patients. At the same time, these suppliers are excluded from participating in innovative payment models.

- **Modified Fee Schedule payment rates threaten access to care in non-CBAs.**

  - The Congress required CMS to extend the phase-in of January 2016 blended rates, but CMS has implemented the provision in a way that results in additional cuts, contrary to Congress' intent.

    - For home oxygen concentrators, CMS applies a budget neutrality factor that results in an 11 percent cut, which means that the rates in rural areas are lower than rates in urban competitive bidding areas.

    - Rather than extend the January 2016 blended rate, CMS has applied the July 1, 2016 competitive bidding rates, which further reduces the blended rate.

  - The costs of providing services in non-CBAs are substantially higher than the costs of providing services to beneficiaries in urban CBAs.

    - A survey of 2014 data from CQRC suppliers found that the cost of providing services in non-CBAs was approximately 18 percent higher than the cost of providing services in CBAs. This difference is likely higher now because CMS has implemented additional cuts since 2014.

- The distances traveled in non-CBAs are greater than those traveled in CBAs. A 2017 CQRC survey found that the distance suppliers must travel for each patient in rural areas is approximately 64 percent higher than the distance traveled in CBAs.

- While fixed costs in non-CBAs may be the same or slightly lower than in CBAs, the number of patients over which the costs can be allocated is substantially smaller, leading to a higher per patient cost. The 2017 CQRC survey found that there are approximately 74 percent more home respiratory therapy patients being served in CBAs than in rural areas.

- Home respiratory therapy beneficiaries in rural areas have limited access to suppliers and competition is decreasing. When analyzing the 2014 Durable Medical Equipment Public Use File (DME PUF), The Moran Company found that in 43 percent of rural areas, Medicare beneficiaries have access to only one or two home oxygen therapy suppliers. In 35 percent of the rural areas, beneficiaries' choices are also limited to only one or two suppliers for home sleep therapies.

- **The Congress should protect the home respiratory therapy benefit. Specifically, the Congress should:**

  - Require CMS to implement the current statutory requirements as written. CMS should not apply the old budget neutrality factor to the new fee schedule rates for oxygen concentrators and should use the January 2016 blended rate for the extended phase-in period.

  - Encourage CMS to use its existing authority to extend the phase-in of the Modified Fee Schedule to allow CMS to develop a methodology for determining rates that accounts for the actual cost of providing items and services to beneficiaries in non-CBAs.