

January 11<sup>th</sup>, 2016

Dear Children, Families, Health, and Human Services Interim Committee,

Thank you for allowing me the opportunity to come and make a public comment about the proposed rule change to ARM 37.85.105 and 37.86.1807, the Montana Medicaid fee schedule for Durable Medical Equipment.

My name is Amy Rients and I work for Juro's Pharmacy Health and Wellness in Billings, Montana. We are a small business serving Montana Medicare and Medicaid patients for over 55 years.

I would like to object to the adoption of the Medicare fee schedule for Durable Medical Equipment for Montana Medicaid.

1. Durable Medical Equipment, like wheelchairs, oxygen, and feeding tubes, enables people with disabilities and chronic illnesses to remain safe and independent at home.
2. The proposed Medicare fee schedule is based on a flawed Competitive Bidding model which reduces reimbursement over 50% on durable medical equipment and in many cases is less than acquisition cost for suppliers. If providers are forced to accept these reimbursement rates for both Medicare (Jan. 1<sup>st</sup>, 2016) and then Medicaid (Feb. 2<sup>nd</sup>, 2016), the results will be devastating for providers and patients who need these services. (Attachment A)
3. More than 240 market auction experts and economists have warned that the Medicare bidding program is unsustainable in its current form. It has damaged the HME infrastructure upon which seniors and people with disabilities rely, including forced bankruptcies, business closures and patients cast adrift to find a provider to repair or replace their life-sustaining medical equipment (Attachment B)
4. No bids have been submitted by Montana providers to come up with competitive bidding rates. These rates are being assigned to rural providers but were established in large urban areas with the promise of increase volume to make up for the reduced reimbursement to bid winners. None of this will happen in Montana.
5. The process to provide a piece of medical equipment through the insurance process is far more complex than just going to the store and buying a piece of equipment for cash. Durable Medical Equipment is heavily regulated to ensure the providers are dispensing equipment appropriately, doctors are prescribing correctly, writing their medical notes according to guidelines; the person needs the equipment, has never received the equipment before and continues to need the equipment. It is a highly complex transaction requiring additional reimbursement to complete all the required regulation. (Attachment C)
6. Providers in Montana have a unique challenge because they are covering the 4<sup>th</sup> largest state in terms of geography yet is 44<sup>th</sup> in size by population. This creates an even larger challenge

for both providers and beneficiaries to have access to services in RURAL Montana.. For some, traveling to a provider for services or a provider traveling to a patient is an extreme hardship.

7. Montana is adding 70,000 more Medicaid recipients to the state and if providers go out of business due to these cuts or simply no longer can afford to service Medicare and Medicaid patients...where will they go?
8. Most providers of durable medical equipment in Montana are small providers who employ people and pay taxes. We are not large corporations that can sustain 50% rate cuts.
9. Most people, given the choice, want to remain in their homes and age in place. As baby boomers age, the rate of spending on long-term care for seniors and those with disabilities, is expected to grow dramatically. Cutting reimbursement to the point of where no provider can afford to supply in home equipment will force a move into hospitals and nursing facilities far more costly to the state. While total Medicare expenses have increased significantly over the last 10 years, DME's share of Medicare spending has been nearly the same. It seems to me that trying to keep people in their home would be less costly to Medicare and Medicaid and is what most people desire. These rules and policies seem to be moving in the exact opposite direction. (Attachment D)
10. There are currently multiple pieces of legislation in the U.S. Congress to replace the competitive bidding process. The most recent bill (S2312) to protect people who need these services but live in RURAL areas is in progress. Both of these pieces of legislation were cosigned by our Montana representatives; Representative Zinke and Montana senators; Senator Tester and Senator Daines. (Attachment E)

Our Montana state representatives Rep. Zinke, Senator Tester, and Senator Daines all know a move to this pricing model would hurt people in our state and specifically people who do not have a loud voice, the poverty stricken, our aging seniors, and small businesses who employ people in our state and pay taxes. We hope the State of Montana will also recognize this need and NOT adopt this flawed pricing model for Montana Medicaid.

Thank you for listening,

Respectfully,



Amy Rients

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# The History of Competitive Bidding

In 2003, the Medicare Modernization Act authorized the Centers for Medicare & Medicaid Services (CMS) to develop a program for home medical equipment (HME) to find market-based prices that would replace the current fee for service prices.

While Congress was cautiously optimistic after the small pilot programs, it halted the original Round One of this auction program in 2008, a mere two weeks after implementation, due to the overwhelming program design and execution problems. The program was nearly unrecognizable from its original pilots and riddled with serious and fundamental design flaws. With a few cosmetic changes to the auction program, CMS began rolling it out to nine selected metropolitan areas in 2011, and added an additional 91 of the largest, most densely populated areas to the program in 2013.

CMS now looks to expand this program to affect all Medicare beneficiaries starting January 1, 2016. While this program, commonly known as "competitive bidding," had the potential to be a valuable cost-saving tool, its current design has put seniors and people with disabilities at risk by creating anemic networks of HME suppliers and awarding these few contracts to those who submitted the cheapest price with little regard to quality, service, experience, financial health, or presence in the community.

## Experts Pan the Program

The program has drawn widespread criticism by numerous patient advocacy groups, and 244 of our country's most prestigious economists and auction experts hailing from institutions like Harvard, Princeton, UCLA, and Stanford wrote a [joint letter](#) to President Obama stating that the program is plagued with "bureaucratic inertia" and called CMS' failure to address core program design issues "especially distressing and unreasonable". The year prior, 167 of them [wrote a letter](#) to then-Chairman Pete Stark (Health Subcommittee, Ways & Means) that "the program over time may degenerate into a 'race to the bottom' in which suppliers become increasingly unreliable, product and service quality deteriorates, and supply shortages become common."

Their professional perspective gets to the heart of the issue. While the concept of a market-based program that encourages smarter government spending is a noble (and necessary) endeavor, the particular attributes of this program design fall short and fail the very people Medicare is trying to protect.

Many beneficiaries subject to the current bidding program experience delays in getting their needed equipment and services, have difficulty finding companies to perform repairs, and are receiving inferior products that the program pricing can barely afford. Instead of accepting help and suggestions offered by esteemed economists and expert auction engineers, CMS emphatically continues onward, expanding the program impact to now encompass the entire nation without any of the critically needed changes.

## Expansion to Rural Areas Causes New Problems

In this newest round of the program expansion, CMS will apply the prices derived from auctions in the 100 largest MSAs to those caring for non-urban and rural America. We are gravely concerned that this will strip Medicare beneficiaries of their community HME suppliers, as the prices aren't reflective of what it takes to properly access, care for, and support these residents.

For example, the amount of fuel, employee time, and vehicle type required to care for an Atlanta, Ga., beneficiary differs significantly from the deep back roads of the Appalachian mountains or one living in North Captiva Island, Fla., that must be accessed via 3-mi ferry ride. Likewise, caring for a beneficiary in Nevada where the state averages a mere 25 people per square mile is drastically different from Orange County in California, even though the prices for Gardnerville, Nev. (population 5,700) will be shaped by the major metro bid areas in that region. The needs of these beneficiaries and what it takes to serve them are as varied as our geographically diverse country. However, this bid program applies homogenized pricing without accounting for the unique factors required to properly provide care for Medicare beneficiaries in different areas.

With irrational, unsustainable prices, many businesses will close, leaving beneficiaries few resources to get their medically necessary equipment, perform essential repairs, and have the personal services and deliveries at home. These companies are far more than suppliers of "bent metal"--they are a critical safety net to help Medicare beneficiaries age in place where they prefer, allowing for better clinical health outcomes, and utilizing the most cost-efficient model of care.

### **Pressure Builds for Congressional Action**

Momentum is building in Congress to legislatively reform the program since CMS is unwilling to make any changes on its own. Representative Tom Price from Georgia has been sensitive to the impact this program has on Medicare beneficiaries and in past Congressional sessions offered an alternative model to establish market-based prices. Now that the program is expanding nationwide, Congressman Price indicates that he will soon introduce new legislation that would change the pricing and phase-in attributes of this national expansion in an effort to protect rural America from a program whose pricing is based off caring for beneficiaries in high density areas. Understandably, this will help lessen the gap between these disparaging differences in serving Medicare beneficiaries across the country.

We welcome the engagement and support of our elected leadership, patient advocacy groups, the HME Industry, and the public on this important issue as we seek to strengthen the Medicare benefit and protect our nation's most vulnerable population and those who serve them.

### History of Cuts to Home Medical Equipment Reimbursement

- 1997 Balanced Budget Act of 1997 (BBA)**  
25% reduction in Home Oxygen Therapy reimbursement effective January 1998
- 2003 Medicare Modernization Act of 2003 (MMA)**  
\$7 billion reduction in Home Medical (HME) over 10 years  
>8% reduction in HME reimbursement as it required Centers for Medicare & Medicaid Services (CMS) adjust HME rates to the *median* prices paid in the Federal Employees Health Benefits Program  
5 year freeze to consumer price index for HME
- 2005 Deficit Reduction Act (DRA)**  
\$500 million reduction in Home Oxygen Therapy reimbursement by capping rental periods starting 2009  
Reduced rental period on certain HME
- 2008 Medicare Improvements for Patients & Providers Act of 2008 (MIPPA)**  
\$3-4 billion (9.5%) reduction in HME reimbursement nationwide  
Required the implementation of a Competitive Bidding program for select HME
- 2010 Patient Protection & Affordable Care Act of 2010 (ACA)**  
\$6-8 billion reduction in HME reimbursement over 10 years by accelerating the Competitive Bidding program, eliminating the first-month purchase option for standard power wheelchairs, and eliminating a 2% increase scheduled for 2014
- 2011 Competitive Bidding Program: Round 1 ReBid**  
\$8.4 billion (32%) reduction over 3 years in select HME in nine metropolitan areas starting January 2011
- 2013 Competitive Bidding Program: Round 2**  
\$12.84 billion (45%) reduction over 3 years in select HME in 100 metropolitan areas starting July 2013  
72% reduction over 3 years in diabetic testing supplies nationwide starting July 2013
- 2014 Competitive Bidding Program: Round 1 ReCompete**  
\$12.9 billion (37%) reduction over 3 years in select HME in nine metropolitan areas starting January 2014
- 2014 Competitive Bidding Program: Nationwide Expansion**  
\$4.4 billion reduction over 5 years in select HME nationwide starting January 2016
- 2015 Competitive Bidding Prices for Complex Rehab Technology Accessories**  
Up to 40% reduction for Complex Rehab Technology wheelchair components (“accessories”) starting January 2016
- 2015 CMS Notice on Web site: Changing Codes & Reimbursement for Ventilators**  
33.5% reduction on positive pressure support and volume ventilators starting January 2016
- 2015 Omnibus Bill**  
\$4.3 billion reduction over 10 years in HME reimbursement in state Medicaid programs by limiting the federal portion of Medicaid funding to the Competitive Bidding rates for Medicare starting 2019

17 June 2011

President Barack Obama  
The White House  
1600 Pennsylvania Avenue  
Washington DC 20500

Cc: Austan Goolsbee, Chairman, President's Council of Economic Advisors  
Cass Sunstein, Administrator, White House Office of Information and Regulatory Affairs  
Kathleen Sebelius, Secretary, Department of Health and Human Services

Dear President Obama,

We are economists, computer scientists and engineers with expertise in the theory and practice of auctions.<sup>1</sup> In September 2010, many of us signed a letter to Congressional leaders pointing out the numerous fatal flaws in the current Medicare competitive bidding program for durable medical equipment (DME). We also emphasized that the flaws could easily be fixed by adopting modern auction methods that have been developed over the last fifteen years and are now well-understood.

The flaws in the auctions administered by the Centers for Medicare and Medicaid Services (CMS) are numerous. The use of non-binding bids together with setting the price equal to the median of the winning bids provides a strong incentive for low-ball bids—submitting bids dramatically below actual cost. This leads to complete market failure in theory and partial market failure in the lab. Another problem is the lack of transparency. For example, bidder quantities are chosen arbitrarily by CMS, enabling a wide range of prices to emerge that have no relation to competitive market prices.

We write today, nine months later, to report that—much to our dismay—there are to date no signs that CMS has responded to the professional opinions of auction experts or taken any serious steps to fix the obvious flaws to the competitive bidding program. Rather CMS continues to recite the mantra that all is well and that CMS does not plan to make any changes to the program as it expands from nine pilots to the entire United States.<sup>2</sup>

We find this especially distressing and unreasonable given your Executive Order of 18 January 2011 on regulation. In that order, you lay out numerous sensible principles of regulation that administrative agencies must follow. The CMS competitive bidding program violates all of the principles, especially the principles of transparency and of basing regulations on the best available science. Indeed, the current program is the antithesis of science and contradicts all that is known about proper market design.

Since the writing of our letter in September, several of us have done further detailed scientific study to explore the properties of the CMS design and contrast it to modern efficient auctions. The

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<sup>1</sup> The views expressed here are our own and do not represent the views of any organization. None of us are paid to provide our views; we provide our independent views as experts who understand the advantages and challenges of market methods. For additional information please contact [Peter Cramton](mailto:pcramton@gmail.com), University of Maryland, [pcramton@gmail.com](mailto:pcramton@gmail.com).

<sup>2</sup> For example, "Laurence Wilson, a Medicare official overseeing the bidding process, said his agency is 'very pleased' with how the nine-city rollout has gone and has no major changes scheduled before the new system starts in large cities." ([CaliforniaWatch.org](http://CaliforniaWatch.org), 26 May 2011, Christina Jewett)

findings are dramatic and illustrate the power of science to inform auction design. Specifically, auction theory was used to demonstrate the poor incentive properties of the CMS design and how these lead to poor outcomes.<sup>3</sup> Laboratory experiments were conducted at Caltech and the University of Maryland that demonstrate that these poor theoretical properties are observed in the lab. Moreover, simple efficient auctions perform extremely well in both theory and in the economic laboratory.<sup>4</sup> Finally, some of us have studied extensively the Medicare setting, speaking with hundreds of DME providers and beneficiaries, and have developed a modern auction design for the setting that is consistent with the best practice and market design methodologies.<sup>5</sup>

This design step was far from a theoretical exercise. On 1 April 2011, a Medicare auction conference was conducted at the University of Maryland to show how the modern auction methods work and to conduct a nearly full-scale demonstration of an efficient auction. Over 100 leaders in government and the DME industry attended the event. The results are documented at [www.cramton.umd.edu/health-care](http://www.cramton.umd.edu/health-care), including a complete video and transcript of the event. The mock auction achieved an auction efficiency of 97%.<sup>6</sup> In sharp contrast, the CMS auction exhibited efficiencies well below 50% in the laboratory, even in simplified environments. Despite these sharp results, CMS continues to assert that all is well and that no significant changes are required.

The problems with the CMS auction grow worse upon closer inspection. The complete lack of transparency is inappropriate for a government auction. For example, we now know that CMS has almost complete discretion with respect to setting prices in a nontransparent way. CMS can and did manipulate the quantities reported by bidders during qualification.<sup>7</sup> These quantities are essential to forming the supply curve, which ultimately sets the price in each product-region. To this date we know little about what quantities were used in the price determination. As a result of this lack of transparency, it is now clear that the CMS design is not an auction at all but an arbitrary pricing process.

Given that nine months have passed and given the disregard by CMS of the market design recommendations received from recognized experts, we call upon the executive branch to direct CMS to proceed otherwise. We also ask that you consider supporting new legislation that requires the Secretary of Health and Human Services to conduct efficient Medicare auctions, consistent with the best practice and the best science.

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<sup>3</sup> Cramton, Peter, Sean Ellermeyer, and Brett E. Katzman, "Designed to Fail: The Medicare Auction for Durable Medical Equipment," Working Paper, University of Maryland, March 2011. [\[pdf\]](#)

<sup>4</sup> Merlob, Brian, Charles R. Plott, and Yuanjun Zhang, "The CMS Auction: Experimental Studies of a Median-Bid Procurement Auction with Non-Binding Bids," Working Paper, California Institute of Technology, April 2011. [\[pdf\]](#)

<sup>5</sup> Cramton, Peter, "Auction Design for Medicare Durable Medical Equipment," Working Paper, University of Maryland, June 2011. [\[pdf\]](#)

<sup>6</sup> Cramton, Peter, Ulrich Gall, and Pacharasut Sujarittanonta, "An Auction for Medicare Durable Medical Equipment: Evidence from an Industry Mock Auction," Working Paper, University of Maryland, April 2011. [\[pdf\]](#)

<sup>7</sup> Tom Bradley, Chief of the Medicare Cost Estimates Unit at the Congressional Budget Office, describes this manipulation in his remarks at the Medicare Auction Conference at minute 49:13, "What they did was they selected bidders up to the quantity well over the amount needed to clear—to serve the given market, and then from that vastly expanded pool, they selected the median. Fundamentally, that's an arbitrary number. It's a number that bears no relationship to the market clearing price." [\[pdf\]](#)

There is much at stake. Unfunded Medicare expenses are estimated to be in the tens of trillions of dollars going forward. Medicare is unsustainable without the introduction of innovative market methods and other fundamental reforms. The DME auction program represents an important first step, especially since failures in homecare will inevitably lead to much more expensive care at the hospital.

We believe that proper design and implementation of market methods can bring gains to all interested parties: Medicare beneficiaries benefit from receiving the quality goods and services they need, Medicare providers benefit from being paid sustainable competitive prices for the quality goods and services they deliver, taxpayers benefit by paying the least-cost sustainable prices for these products, and CMS benefits from the numerous efficiencies that result from conducting an effective program, largely free of complaint, fraud, and corruption.

We believe that government plays an important role in establishing effective market rules. For the Medicare auctions, the impediments to reform are not special interests or a lack of knowledge, but bureaucratic inertia. This is an important setting and change of the prior administration's regulations is required to contain Medicare costs and assure quality services for Medicare beneficiaries. We are counting on your leadership to bring effective reform.

Many thanks for your thoughtful consideration of our concerns.

Sincerely,

*[The following are economists, computer scientists, and engineers with expertise in the design of auctions and market mechanisms. Information on each of us, including our auction-related research, can be found with an Internet search of name and affiliation.]*

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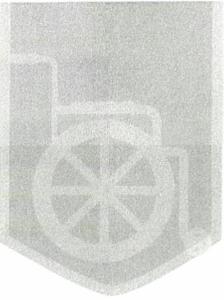
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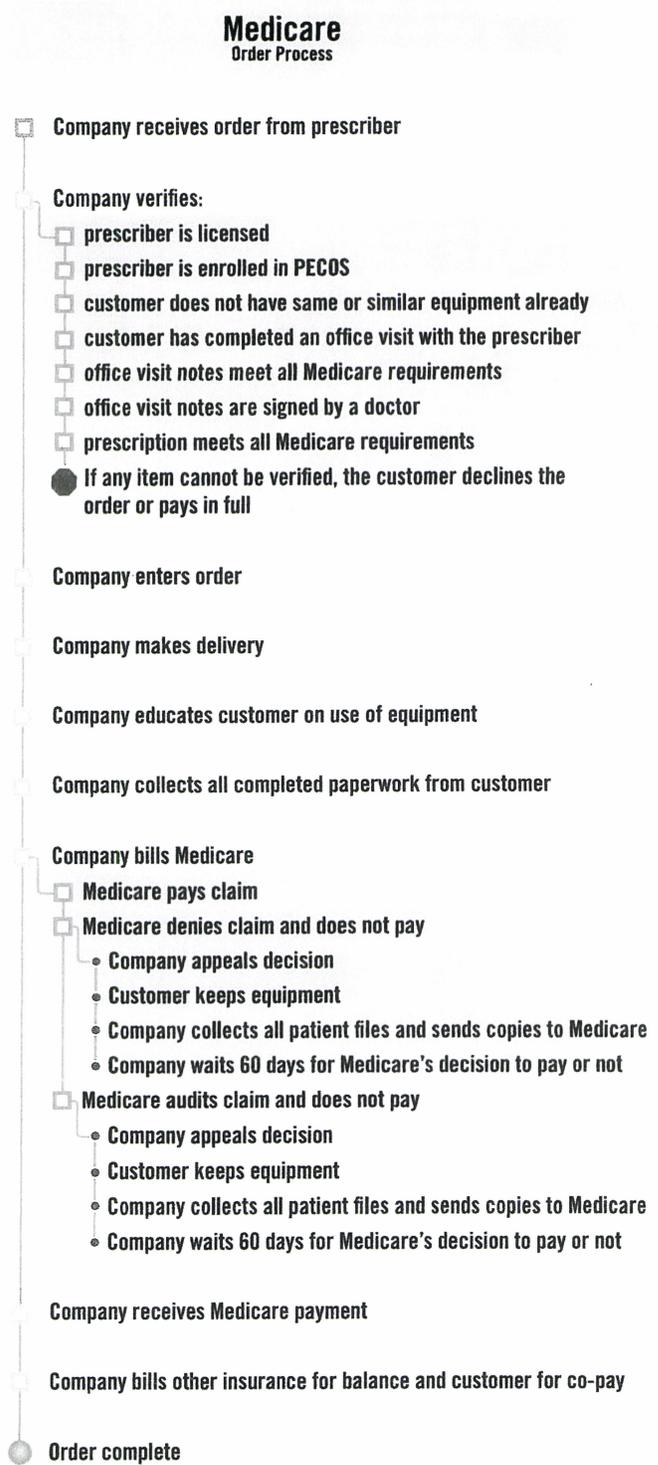
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Sven Seuken Harvard University	Simon Wilkie University of Southern California	



# Durable Medical Equipment

Attachment C

## How the Medicare order process compares to retail and online purchases



Medicare can audit claims and take back payments for **up to 7 years** after a claim is paid.



# MINNESOTA

LOCAL • STATE • REGION

## State sees \$1B drop in health care costs

Medicaid savings came from low-income enrollees; most spent on elderly, disabled.

By RICARDO LOPEZ  
ricardo.lopez@startribune.com

Minnesota state leaders trying desperately to tamp down expenses have found an unlikely area where they saved more than \$1 billion — health care for low-income residents.

State officials are starting to see results after taking aggressive steps in recent years to

Minnesota launched a competitive bidding process statewide that trimmed payments to some managed-care providers and is expected to save the state \$234 million over the current two-year budget period, according to the Department of Human Services.

State officials were surprised that new enrollees in the state's Medicaid program "were actually healthier" than what they projected, said state budget director Margaret Kelly. "There were similar

things going on in our MinnesotaCare," said Kelly, noting that new enrollees also were healthier than expected and the share of federal contributions has grown.

Minnesota spent \$4.6 billion on Medicaid and MinnesotaCare in 2014, about \$1.2 billion less than what had originally been projected, according to Senate fiscal research and the Minnesota Management and Budget agency.

Two-thirds of that Medicaid spending, \$3.1 billion, paid

for nursing homes and other services for seniors and those with disabilities. By comparison, spending on other Medicaid participants such as single adults and families with children was \$1.5 billion. MinnesotaCare accounted for \$254 million of that overall spending.

Legislators and human services officials in the coming years will grapple with how to best manage the growing cost of caring for the state's aging population. Older residents

See **HEALTH** on B9 ▶

### STATE SPENDING

**\$4.6B** Total spent on Medicaid and MinnesotaCare in 2014.

**\$3.1B** Share of Medicaid spending that went to seniors and those with disabilities.

**\$1.5B** Share of Medicaid total that went to single adults and families with children.

# State sees payoff in medical aid

◀ **HEALTH** from B1

are more likely to require more expensive medical treatments for chronic conditions or other ailments.

"That's the portion of our budget that's the largest ... from a state dollar perspective and the part that continues to grow," said Chuck Johnson, deputy commissioner for the Department of Human Services.

To that end, Minnesota is working toward encouraging the use of more home-based services, which are cheaper compared to services and treatments in hospital settings.

The rate of spending on MinnesotaCare and Medicaid recipients such as adults and families with children is expected to be relatively modest, growing about 6 percent between fiscal years 2012 and 2019, according to Senate research.

By comparison, the rate of spending on long-term care, seniors and those with disabilities is expected to grow 52 percent over the same period.

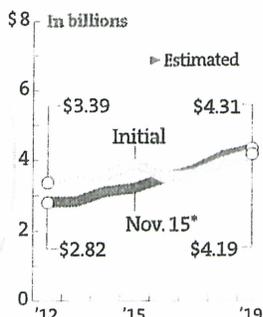
## MinnesotaCare's future

Last year, the GOP-controlled Minnesota House voted to eliminate MinnesotaCare, arguing that the roughly 100,000 people covered under the program could be moved onto the state health insurance exchange. Fierce opposition by state Democrats and others resulted in a legislative budget compromise that spared the program, for now. A 29-member task force is studying its future and is expected to develop recommendations

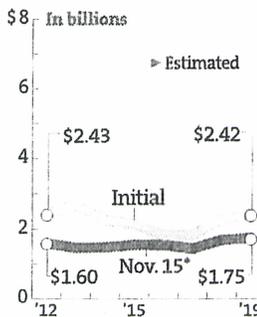
## STATE MEDICAL ASSISTANCE SPENDING

Since 2012, actual spending on medical assistance programs, including Medicaid and MinnesotaCare, have come in below state projections, partly because of healthier insurance populations and other state changes. Spending on the elderly and disabled populations is expected to grow at a faster rate.

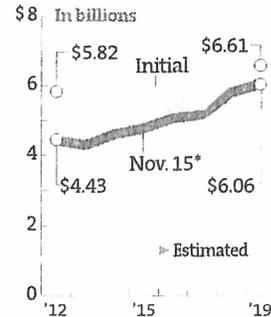
### Long-term care/elderly and disabled basic



### Single adults, families with children and MinnesotaCare



### Total medical assistance programs



\*November 2015 budget forecast estimates included updated enrollment data and new projections following the implementation of a statewide competitive bidding process last year.

Source: Senate fiscal research

MARK BOSWELL • Star Tribune

on its fate. Though it is unclear how legislators will act on the program, the task force also will have to consider how to act on a special tax that makes up the bulk of its funding. The tax is set to expire in 2019.

State Rep. Matt Dean, chairman of the House Health and Human Services Finance Committee, argues that Minnesota would be better served in the long run by ending MinnesotaCare. Those low-income workers, primarily concentrated in rural parts of the state, could shop on MNsure, the state's health insurance exchange, and find more choices, he said.

That action would also create "a broader, more robust pool of people who are purchasing insurance in Minnesota," said Dean, R-Dellwood, potentially driving down pre-

miums.

State Sen. Tony Lourey, chairman of the Senate Health and Human Services Finance Committee, countered that it makes little sense to eliminate MinnesotaCare, particularly since the growth rate of spending there is low compared with spending on seniors and those with disabilities.

## Competitive bidding savings

Lourey, DFL-Kerrick, said updated projections in November showed MinnesotaCare costs the state less, partly the result of competitive bidding.

Estimates by the state budget office from last summer showed that overall the monthly cost of MinnesotaCare per enrollee was \$537. The most recent forecast showed the cost is now

expected to be \$413 per month, of which nearly 70 percent is paid by federal funding, up from 42 percent last summer.

"My concern is that when folks look at the total [medical-assistance] growth and blame MinnesotaCare and say we need to eliminate MinnesotaCare and that fixes this problem — that's just not true," Lourey said.

Johnson, of the state Human Services agency, says the state will face budget challenges as its demographics shift. "Our overall state Medicaid budget will continue to be driven by the cost of serving seniors and people with disabilities, and we're working as best as we can to manage the cost of care and to provide the best value we can for people," Johnson said.

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## BID EXPANSION REFORM NOT PART OF SPENDING BILL

Rural provider protection was not put into year-end omnibus spending bill; effort to back bid reform and CRT protection bills continues.

- By David Kopf
- Dec 17, 2015

Legislative language that would have reformed CMS's nationwide expansion of the competitive bidding program to lessen the burden on rural providers was not incorporated into the Omnibus spending legislation package that is slated for a Congressional vote on Friday, according to the American Association for Homecare.

Provisions that were not included included language that would have lengthened the timetable for implementation of the expansion; decreased the reimbursement cut for rural providers; and protected funding for complex rehab accessories. The Medicaid "pay for" that industry advocates had targeted to help pay for the rural relief legislation has been included in the Omnibus legislation, with a 2019 effective date.

"This result is not a reflection of the amount of effort that our industry has extended at both grassroots and Capitol Hill lobbying levels, and we should all be proud of the way the AAHomecare membership, our state/regional association partners, and other leading stakeholder organizations and allies have come together to build support for these initiatives," a statement from AAHomecare read.

The association reported that there might be other vehicles to which the legislative language could be attached, such as Medicare-related legislation in early 2016. Also, the association stressed that there is still opportunity to get its House and Senate rural protection bills passed during 2016, as well, and encourage providers to continue lobbying their lawmakers on their behalf.

Those two bills are H.R. 4185, titled The Protecting Access through Competitive-pricing Transition (PACT) Act, which was introduced into the House by Reps. Tom Price (R-Ga.) and Tammy Duckworth (D-Ill.); and S. 2312, the DME Access and Stabilization Act, which was introduced into the Senate by Sens. Senators John Thune (R-S.D.) and Heidi Heitkamp (D-N.D.).

Those bills would:

- Apply a 30 percent increase to single payment amounts (SPA), calculated on a regional basis, for suppliers in non-bid areas.
- Phase in the bidding-derived pricing over a two-year period in non-bid areas, rather than CMS's six-month phase-in.
- Set the ceiling for future bidding rounds of the competitive bidding program at the unadjusted fee schedule rates that went into effect on Jan. 1, 2015, instead of CMS' proposal to set a bid ceiling at the previous bid amount rates. The AAHomecare noted this is an important component of the legislation that will benefit all providers subject to competitive bidding rates in future bidding rounds.
- Instruct CMS to revisit pricing adjustments for non-bid areas that takes into account travel distance, clearing price and other associated costs for furnishing this equipment for prices that will be in effect on Jan. 1, 2019.

The House bill would also implement a Market Pricing Program (MPP) demonstration project in order to compare an alternative methodology for achieving sustainable savings while preserving access to medically necessary equipment, supplies, and services to beneficiaries.

Also, providers were encouraged to continue advocating on behalf of legislation that would protect accessories for complex rehab wheelchairs. There are two bills the industry is trying to get passed: H.R. 3229, which was launched into the House by Rep. Lee Zeldin (R-N.Y.); and S.2196, launched into the Senate by Sen. Robert Casey (D-Pa.) with Sens. Rob Portman (R-Ohio), Chuck Schumer (D-N.Y.) and Thad Cochran (R-Miss.) as original co-sponsors for the legislation. The bills provide a technical correction that restricts CMS from applying Medicare competitive bidding program pricing to the accessories used with complex rehab wheelchairs.