March 28, 2014

Via Electronic Mail:

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Methodology for Adjusting Payment Amounts for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) using Information from Competitive Bidding Programs, [CMS-1460-ANPRM] RIN: 0938-AS051

Dear Administrator Tavenner:

The American Association for Homecare (AAHomecare) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services’ (CMS) Advance Notice of Proposed Rulemaking (ANPRM) titled “Medicare Program; Methodology for Adjusting Payment Amounts for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) using Information from Competitive Bidding Programs”. AAHomecare represents DME providers and manufacturers with over 3,000 locations nationwide.

As the Association that represents the durable medical equipment industry, we believe we have a unique perspective to support CMS as they consider applying payment rates from the Medicare competitive bidding program to areas outside of competitive bidding areas (CBAs). We believe this program was poorly designed and implemented in a disorganized fashion. We are especially concerned about CMS establishing the single payment amounts (SPAs) at the median rather than the clearing price, the lowest price in the array of bids that would meet expected capacity. Fifty percent of all winning bidders stipulated that this was the lowest price at which they could provide the equipment and services under the request for bids. Under this methodology, we believe the SPAs do not reflect true market pricing. Expansion of the bidding program by using SPAs to adjust Medicare reimbursement outside of CBAs would create significant hurdles to access for beneficiaries and place the infrastructure of an important part of the continuum of care at risk. Based on what we know about the program from our members, we hope that CMS refrains from applying the SPAs to areas outside the CBAs until the Office of Inspector General has released their reports on Round 1 and Round 2 of competitive bidding.

1 79 Fed Reg 10754 (February 26, 2014)
program, or the program is replaced with the market pricing program (MPP) in the Medicare DMEPOS Market Pricing Act of 2013 (H.R. 1717) and reasonable competitions can take place. CMS has also requested comments on whether the Agency should create a bundled payment system for DME and enteral equipment, nutrients, and supplies using competitive bidding. Our understanding is that CMS intends to establish one bundled rental payment for all the DME and enteral equipment and related supplies a beneficiary would need during a period of medical necessity. The bundled monthly rental payment would replace the current rental and routinely purchased payment categories established by Congress. We believe CMS does not have the authority to replace the payment categories under the fee schedules with a new bundled payment for DME and enteral products. Competitive bidding may be used to determine new payment amounts for items and services, but Congress intended the payments to be made according to the payment rules established under §1834(a) and (h) of the Social Security Act.

AAHomecare is opposed to these two proposals. We believe that these proposals would cause an undue burden on providers because the SPAs are artificial numbers that do not reflect providers’ costs of doing business in a CBA. AAHomecare would like to meet with CMS to discuss these issues and possible alternatives. In the meantime, we discuss our concerns in more detail below.

I. BACKGROUND AND SUMMARY OF COMMENTS

A. The competitive bidding program is deeply flawed; the SPAs cannot be used to adjust Medicare payments in areas outside of CBAs.

We believe the competitive bidding program’s methodology has been deeply flawed since the program’s inception. The program’s design flaws are so far afield from the typical commercial or government auction that approximately 244 auction experts, including three Nobel laureate economists, felt compelled to address concerns with President Barack Obama over what they felt was a program that did not meet typical commercial or government auctions. The economists analyzed the bid submission and selection components of the program and concluded that these key design features systematically skew bid pricing downward.

First, bidders are not bound by their bids. In typical auctions, bidders must be prepared to do business at the price they bid. Under the Medicare program, however, a low-ball bidder who is awarded a contract does not have to accept it if the price is too low. Because bidders are not compelled to accept a contract award, there is no penalty for submitting irrational bids that result in unsustainable pricing. Low-ball bidders are free to reject a contract offer, but their low bids are used to calculate the SPAs.

Second, the SPAs are based on a flawed pricing mechanism. SPAs are set at the median of the initial contract offers, meaning half of the “winners” are offered a contract below their bids, which represented the lowest amount at which they could supply the product and services while remaining profitable. We believe this, too, encourages low-ball bidding because a very low bid guarantees winning, but low-ball bidders can be reasonably sure they will be paid at a higher rate.

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3 Ibid.
4 Ibid.
Third, the use of composite bids tends to skew bids downward because bidders can bid low on high-demand items and high on low-demand items. The result is that bids do not reflect the providers’ costs.\(^5\)

We believe the lack of transparency in awarding contracts undermines the credibility of the process. Suppliers do not know how CMS applies the quality and financial standards to individual providers.\(^6\)

In addition to adopting a fundamentally flawed competitive bidding design, CMS has administered the program haphazardly. CMS has accepted bids from bidders that did not meet the minimum requirements of the program, such as having a license in the state where they bid. Unlicensed bidders have not invested the time or resources to meet the most basic requirements for doing business in a state and we believe they are likely to submit low bids that would skew the SPA downward.\(^7\)

We believe CMS violated its own rules by accepting bids from unlicensed bidders and using those bids to calculate SPAs. It is our understanding that CMS has taken action against some unlicensed bidders, but has not revised the SPAs that included bids from unlicensed bidders. As a result, the SPAs in those CBAs are flawed and cannot be fairly applied to adjust Medicare payment amounts in other areas.

We recognize that competitive bidding can lower payment amounts, but we believe there is no credible evidence that the program has in fact met its goal of protecting the quality of equipment and services that beneficiaries receive. The program has not been evaluated to determine its effects on beneficiary access, the quality of equipment that is being furnished, or its impact in rural areas, Alaska, Hawaii, and the U.S. territories. AAHomecare members have identified significant access issues for beneficiaries who need to change providers in order to purchase supplies for equipment they own. The competitive bidding rules for reimbursement of supplies used with patient-owned equipment, coupled with CMS’ burdensome audit policies, make it difficult for patients to change providers if they are unable establish medical necessity for base equipment that was furnished by another provider. AAHomecare has reported to CMS that thousands of Medicare beneficiaries are caught in this situation. However, we have not seen any action from CMS to reconcile the conflict between the goals of competitive bidding and program integrity.

We ask that CMS use the market clearing prices or pivotal bids, instead of the SPAs, as the starting point when calculating prices in non-CBAs, as these numbers represent true market pricing. Additionally, we ask that CMS adjust the market clearing prices upward to account for the unique aspects of doing business in rural areas. It is much more difficult to service rural areas because providers have lower patient volumes to offset any competitive bidding price reductions. Providers in these areas do not have the same buying power because of the generally lower patient volumes. In addition, there are numerous geographic factors that make serving beneficiaries in rural areas more expensive.

**B. Payment for DME and enteral equipment, nutrients, or supplies cannot be bundled.**

1. A bundled payment methodology cannot be implemented without a careful assessment of the needs of patients who use DME and enteral therapies and the costs to providers for furnishing that care.

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\(^6\) *Ibid.*  
\(^7\) Attestation of Peter Cramton, Professor of Economics, University of Maryland, filed in American Association for Homecare, et. al. v. Kathleen Sebelius, Civil Action No. 13-00922-BAH.
The ANPRM states CMS’ intent to establish one bundled monthly rental payment for all the DME and enteral equipment and related supplies a beneficiary would need during a period of medical necessity. The bundled monthly rental payment would replace the rental and routinely purchased payment categories established by Congress under the fee schedules. We are concerned by this proposal. AAHomecare believes CMS lacks data that could be used to align an individual’s medical necessity for equipment and services to the Medicare payment for those items and services. In addition, we think this type of bundling would be so complex that it would be premature to implement this methodology under the DMEPOS benefit without a comprehensive analysis of the costs to furnish equipment to a chronically ill patient with a progressive condition.

Unlike the home health or skilled nursing facility (SNF) prospective payment systems (PPS), this proposal seems to lack any mechanism to tie the medical needs of an individual patient to the payment for the items and services that a patient may need. The PPS methodology relies on a comprehensive patient assessment to determine the care and intensity of the services a beneficiary will use. The home health and SNF PPS also include factors for adjusting payment amounts to account for individuals who require more or less care than typical patients with similar conditions. Finally, the PPS methodology takes into account geographic variations in the costs relevant to a SNF or home health agency and adjusts the episodic payment accordingly.

We believe that a significant amount of time for data collection is required to design and validate this type of comprehensive assessment tool. We do not believe CMS can create a similar tool given the lack of data about DMEPOS patients it has today. DMEPOS claims data cannot adequately be used as a substitute for the data necessary to create a bundled payment system. Claims data only shows claims that were submitted for payment, but does not provide information with respect to a beneficiary’s medical condition and continued need for the equipment or enteral therapies. Many factors can explain a stop in claim submissions, including a provider going out of business, or a provider suspending billing pending an audit. CMS cannot look at the number of months of rental or services claims submitted and conclude that these were the total services a patient needed or received.

2. Competitive bidding, as designed under the current CMS program, is not the proper way to determine payment amounts for bundled DME and enteral therapies.

DME and enteral products cannot be bundled the same way oxygen and oxygen equipment were bundled when the fee schedules were adopted 25 years ago. At that time, oxygen patients were a homogenous group with comparable needs from one patient to another. The equipment and services the patients needed were generally predictable at the start of their care. The technology available at the time was very similar and does not represent the array of technology available to patients today.

In contrast, CMS proposes to include equipment-centered bundles in a competitive bidding program and allow providers to determine applicable costs on the basis of their bids. First, we believe there is no data to establish what bundles may be appropriate for specific patients, and no coverage criteria to determine when a beneficiary qualifies for a bundle of equipment, services, and supplies. For enteral therapies in particular, many beneficiaries do not require enteral equipment. In addition, the type of formula they use and the volume of calories each beneficiary may need vary greatly making it very difficult to establish a bundled payment amount at the initiation of their care.
Second, without assessment criteria similar to the ones used for the home health and SNF PPS, providers have to guess at the type of equipment and the frequency of the services different patients may need. Without an assessment tool, CMS has no way of comparing bids for a bundle because there is no consensus on what it takes to service patients who receive the bundle. More importantly, even assuming that these issues could be addressed in the near term, we do not believe that payment amounts for the bundled items and services obtained under the current competitive bidding program would be sufficient to allow providers to remain operational.

3. A bundled payment methodology for DME and enteral therapies would likely be more expensive for beneficiaries and has the potential to create hurdles in access to care for beneficiaries with acute, short-term needs for DME or enteral therapies.

We believe a bundled payment system for DME would not be helpful to beneficiaries. For example, beneficiaries with short-term, service-intensive needs might find it more difficult to access care compared those with long-term, stable, chronic conditions. These longer-term stable patients would, in turn, subsidize the care of acute beneficiaries. Beneficiaries with long-term chronic conditions would also pay more in copays because they would never own their DME and rental payments for enteral equipment would never “cap.”

Further, a bundled payment methodology would not eliminate the requirement that beneficiaries establish medical necessity for equipment or services if they decided to change their provider. The new face-to-face regulations also compound what is already a very difficult situation for beneficiaries. The face-to-face regulations require beneficiaries to have an in-person assessment by a physician or certain non-physician practitioners to determine the need for DME their physicians prescribe. Providers must have documentation of the encounter and a written order prior to delivery of the equipment. CMS has interpreted this rule to apply every time a beneficiary changes providers. Under a bundled payment methodology, beneficiaries will still need to comply with this rule as they do now under current payment rules. This will cause some beneficiaries to experience delays in getting their equipment or enteral therapies and some will have to pay for these items out of pocket.

4. Medicare must continue to pay for maintenance and service to beneficiary-owned DME and enteral equipment and for the replacement and customization of accessories for the equipment.

We believe this proposal is based on CMS’ belief that Medicare pays too much for equipment without accounting for the support services that are included under the monthly fee schedule amount. AAHomecare supports CMS’ goal to meet beneficiaries’ needs cost effectively. However, we believe this proposal runs counter to that goal. We believe that CMS is aware of the adverse impact limiting reimbursement for the Medicare oxygen benefit has had on beneficiary’s ability to change providers, which significantly limits their access to care. We believe the best way to protect beneficiaries’ ability to receive quality care in a timely fashion is to ensure that Medicare payment amounts for DME and enteral therapies are adequate for providers to remain operational.

II. AAHOME CARE’S RESPONSE TO CMS QUESTIONS

A. The SPAs under the current competitive bidding program are not reflective of the costs to providers of serving Medicare beneficiaries within a CBA.
1. Do the costs of furnishing various DMEPOS items and services vary based on the geographic area in which they are furnished?

Yes. Costs will vary significantly based on geographic area and must be taken into consideration in any change in reimbursement methodology. The original fee schedules accounted for these differences by using charge data from each state to establish payment amounts. The most significant variables that affect costs are labor, transportation, and regulatory costs. For example, a majority of states require that respiratory therapists perform CPAP set-ups, and a smaller number of states also require therapists for oxygen set-ups. Suppliers in states where professional staff must perform these services have a higher cost of doing business compared to providers in states that don’t have those requirements.

Appendix 1 shows how fuel costs vary across states. Appendix 2 shows the variability in the SPAs by CBA demonstrating the geographic variability across CBAs.

a) If so, how should bidding information from programs established in certain regions of the nation be grouped together for the purpose of adjusting current Medicare payment amounts?

Pricing data derived from a fairly constructed and administered market pricing program would reflect the costs of doing business in a bidding area. However, the data from the Medicare competitive bidding program is not an appropriate measure of providers’ costs to do business in a CBA. The Medicare competitive bidding program has systematically skewed bid pricing downward. Consequently, SPA data from the CBAs are unreliable and cannot be applied to areas outside the CBAs. Pricing data from one CBA cannot be used to adjust Medicare payment in another state unless those differences are accounted for.

b) Should bidding information from programs established in certain regions of the country be used to adjust the payment amounts that currently apply to those regions?

No. The SPAs from many CBAs were based on bids submitted by out-of-state or area providers who either were not aware of the costs of doing business in the CBA or did not invest the time and resources to meet the state’s regulatory requirements. State licensing and other regulatory requirements for DMEPOS providers can serve as a measure of the cost of doing business in a state. State licensing statutes will specify requirements for professional staff, physical plant, and provider quality standards that often exceed those required nationally under the Medicare program. We believe that providers that do not meet these requirements at the time they submit a bid are more likely to submit a lower bid than licensed providers because they are not aware of the costs of doing business in a state.

Further, because CMS awarded contracts to unlicensed out-of-state providers, CMS cannot use the bids from CBAs adjacent to the rural areas as proxies for the cost of doing business in the state. As we discussed above, bids from unlicensed providers do not reflect the costs of doing business in an area. Unlicensed providers have not actually incurred any costs from doing business in a state before they submit a bid. Consequently, in the current bidding program, bids from out-of-state providers have skewed bid prices downward compared to the bids submitted by companies who are licensed and meet the regulatory requirements in the state. CMS must remove these bids from the bid pool and recalculate the SPAs using only bid data from licensed providers before using the data to adjust Medicare pricing in.
areas adjacent to a particular CBA. To use this competitive bidding pricing information, we believe CMS should: 1) recalculate the bids by excluding the bids submitted by out-of-state unlicensed providers; 2) increase the recalculated SPAs by 50%.

c) Are there certain areas of the country that have unique costs and how should those costs be considered?

Yes, Alaska, Hawaii, and the U.S. territories have unique cost structures. One factor that needs to be taken into account for Alaska, Hawaii, and the U.S. territories is that the acquisition cost of equipment is much higher for providers physically located in the state or territory. AAHomecare manufacturer members have reported to us that providers in those areas are responsible for all freight charges for the equipment they buy. Within these areas, the cost of serving beneficiaries also varies. For example, our members report that even within Alaska or Hawaii the costs of doing business in one part of the state may be much higher than in another. Alaska is also subject to requirements of the Jones Act, which makes shipping into the state extremely expensive. Our manufacturer members report that it is “drastically more expensive” to ship to Alaska and Hawaii than it is to ship within the lower 48 states. Finally, some members have reported closing branches in rural areas and places like Alaska because they can no longer afford to keep them open given the loss of revenue for branches located in CBAs.

Some areas also have costs that are unique to that specific location. For example, in addition to the typical costs associated with fleet maintenance, such as fuel costs and other transportation costs, providers who service New York City must budget for traffic tickets, longer delivery times due to congestion, and delays because their trucks are subject to searches on bridges. New York providers also include two drivers on vehicles because they often need to double-park.

d) Is there valid and reliable information that can be used to measure the relative costs of furnishing items and services in these unique areas?

We believe that there is no reliable information on the cost of furnishing DMEPOS items in Alaska, Hawaii, and the U.S. territories. As we noted above, we know from our members that acquisition costs in these areas are higher as a result of higher shipping costs. Our members also report that it is generally more difficult and more expensive to service individual beneficiaries in these areas as a result of inadequate roads and other infrastructure.

2. Do the costs of furnishing various DMEPOS items and services vary based on the size market served in terms of population or distance covered or other logistical or demographic reasons?

Yes. Population density is an important factor in determining the costs of furnishing DMEPOS. Both high and low population densities can raise the cost of furnishing DMEPOS. At both extremes transportation costs (which are providers’ highest costs next to labor) can be impacted upwards. As we noted above, providers that service New York City face unique challenges as a result of traffic concerns and security concerns in that part of the state. The SPAs are based on the assumption that providers will increase market share to offset the reduction in their reimbursement. This is not possible in areas where population levels and the number of Medicare beneficiaries are low.

3. How should any future adjustments or payment methodology treat payment amounts for items that have not been included in all competitive bidding programs (for example, items
such as transcutaneous nerve stimulation (TENS) devices that have only recently been phased into the round 1 areas thus far)?

Our understanding is that CMS only has authority to apply competitive bidding pricing from the competitive bid areas to other areas of the country. It cannot make payment adjustments based on competitive bidding for items that were not competitively bid. Any items that were excluded from competitive bidding must be excluded from payment adjustments based on competitive bidding pricing. We would ask that CMS refrain from using the SPAs for items that have only recently been the subject of competitive bidding. There simply is not sufficient history with these items under competitive bidding.

4. Should competitive bidding programs be established in all areas of the country for a few high volume items in order to gather information regarding the cost of furnishing DMEPOS items in general in different areas of the country (for example rural areas as well as urban areas)?

This question is unclear. If CMS intends to establish new national competitive bidding programs for a product category, CMS must provide additional information on what it intends to do. AAHomecare does not believe that there are any products that could appropriately be included under a national mail order competitive bidding program.

5. For payment adjustments or competitive bidding programs in rural areas what factors should be used in determining a competitive service area in terms of Medicare revenue available and logistical costs of serving the area?

We believe that competitive bidding is not appropriate in rural areas. Congress excluded rural areas from competitive bidding prior to 2015 and gave CMS the authority to carve rural areas out of competitive bidding altogether. We believe that rural areas do not have a high enough number of beneficiaries to offset the price reductions that would result from implementation of competitive bidding. In addition, some rural areas may lack adequate infrastructure like roads and other utilities to support the delivery of items in a timely manner. As we noted above, some of our members report that they have closed branches in rural areas because the price reductions from competitive bidding no longer allow them to cross-subsidize less profitable rural branches. These factors make rural areas inappropriate for competitive bidding or payment adjustments based on SPAs. The latter option is particularly problematic because, as we have explained above, the SPAs do not reflect providers’ costs of doing business in a CBA.

a) Are there ways to determine which rural counties should be served by which providers?

No. AAHomecare recommends that CMS refrain from implementing competitive bidding programs in rural areas. AAHomecare also recommends that CMS carefully assess the impact of the current competitive bidding programs have had on rural areas. Even though rural areas and certain urban areas were excluded from competitive bidding, AAHomecare believes that the competitive bidding program has caused unintended consequences in some of those areas. Suppliers have closed branches in hard to serve areas because the cost of keeping them open can no longer be offset by revenue from other branches located in CBAs. If CMS is contemplating awarding an entire rural area to a single provider, it must also consider the impact that will have on access in the state’s health care marketplace including access to providers under commercial payers and the state Medicaid program. A provider’s enrollment in Medicare is deactivated if it does not bill Medicare at least once in a year. Because Medicare
enrollment is a criterion for participation in some state Medicaid programs and commercial payers, providers may no longer be eligible to participate in Medicaid if they are excluded from serving beneficiaries in rural areas. Awarding an entire rural area to one provider or an out-of-state provider would likely disrupt the availability of DMEPOS items and services to Medicaid recipients and commercial plan enrollees.

6. What additional factors should be considered and why?

We believe the current competitive bidding program is flawed. The program flaws have systematically skewed bid pricing downward and has encouraged bidding that is not reflective of providers’ costs.

AAHomecare is unaware of any investigation into the unintended consequences of the program in rural areas outside CBAs. We believe that a comprehensive analysis of the impact of competitive bidding on beneficiary access to supplies both within and outside the CBA’s should be conducted. We would also ask that CMS consider how its coverage, documentation, and audit policies have affected beneficiary access to DMEPOS under competitive bidding. For example, beneficiaries cannot easily change providers within CBAs unless they can establish medical necessity for the equipment they use. Beneficiaries who do not have the necessary documentation from their physician must requalify for the equipment or pay for it out of pocket. Documentation requirements, difficulty or delays in receiving necessary documentation from physicians, and audits also divert providers’ time and money away from patient service, which, coupled with the unsustainable price reductions from competitive bidding, can have a detrimental effect on their ability to remain operational.

B. Payment for DME or enteral equipment, nutrients or supplies cannot be bundled.

1. Are lump sum purchases and capped rental payments rules for DME and enteral nutrition equipment that were implemented to prevent prolonged rental payments still needed now that the monthly payment amounts can be established under competitive bidding programs for furnishing everything the beneficiary needs each month related to covered DME items or enteral nutrition?

A. CMS does not have the authority to substitute a bundled payment for DME and enteral therapies in place of the payment rules that Congress established under the Social Security Act.

We do not believe that CMS has the authority to establish a bundled payment system for DME or enteral therapies in place of the payment rules Congress established under the Social Security Act. CMS’s authority under §1847 of the Social Security Act is limited to establishing payment amounts for DME and enteral therapies using competitive bidding. Congress never intended for CMS to use the authority under §1847 to replace the payment rules it created under §1834 (a).9

Congress did specify under §1834 (a) that CMS must use the payment amounts derived under competitive bidding as the payment basis for DME furnished under the statute. However, CMS’ authority is limited to using the SPA as the payment basis for DME. Congress also refrained from extending CMS’ authority to making changes to the payment rules specified under §1834 (a) (2)-(7).

8 42 U.S.C. §1395w-3
9 42 U.S.C. §1395m
Those sections establish six carefully thought out classes of DME and specify the payment rules applicable to each class, including equipment in the routinely purchased and capped rental payment categories.

Section 1834(a) was added to the Social Security Act by §4062 of the Omnibus Budget Resolution Act of 1987 (OBRA)\(^{10}\) and established a six-point plan for Medicare payment of DME. Given the diversity of DME and the purposes for which it is used, Congress tied reimbursement for the equipment to the type of equipment and the cost of Medicare paying for it. Section 1834 (a) created six classes of DME: inexpensive or routinely purchased, frequently serviced, oxygen and oxygen equipment, customized items, and other DME.\(^{11}\) The payment basis and the rules that control how frequently a payment is made are tied to the type of equipment used.\(^{12}\) In contrast, §1847 authorizes CMS to determine SPAs for DME based on providers’ bids for items and services, but generally does not address the rules for making such payments.\(^{13}\)

Under §1834 (a) the payment basis for DME is either 80 percent of the provider’s actual charge for an item or the fee schedule amount for each class of equipment calculated with the formula specified under the statute.\(^{14}\) There is only one exception to this rule. Section 1834(a) (1) (F) (i), requires that the Secretary use the SPA derived through competitive bidding in a CBA as the payment basis under §1834 (a) for an item or service furnished in the CBA.\(^{15}\) However, the structure of the payment provisions for each category of equipment shows that Congress did not intend to relinquish its control over the payment rules for DME to the Secretary as a result of competitive bidding. For each class of equipment, §1834 (a) specifies both the frequency of payment and the payment amount for the equipment. To avoid ambiguity, §1834 (a) (1) (A) distinguishes between the rules that determine the frequency of payment and how the payment basis is determined. Section 1834 (a) (1) (A), states, in part:

(a) Payment for durable medical equipment

(1) General rule for payment

(A) In general

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\(^{10}\) PL 100-203 (1987)

\(^{11}\) 42 U.S.C. §1395m (a) (2)-(7)

\(^{12}\) 42 U.S.C. §1395m (a) (1) (A) & (B)

\(^{13}\) 42 U.S.C. §1395w-3 (b) (5)

\(^{14}\) 42 U.S.C §1395m (1) (B), states, in part:

Subject to subparagraph (F) (i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item, or

(ii) the payment recognized under paragraphs (2) through (7) of this subsection for the item .]

\(^{15}\) §1395m (a) (1) (F), states, in part:

(f) Application of competitive acquisition; limitation of inherent reasonableness authority In the case of covered items furnished on or after January 1, 2011, subject to subparagraphs (G) and (H), that are included in a competitive acquisition program in a competitive acquisition area under section 1395w-3(a) of this title--

(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program;
With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

Under the statute, the frequency of the payment for is equipment is tied to its payment category. Both the payment frequency and the payment amount for a type of equipment are defined for each payment category. Section 1834 (a) (2) (A) for example, establishes that the frequency of the payment for inexpensive or routinely purchased equipment can be either a rental payment or a one-time, lump-sum purchase of the equipment; whereas, the amount of the payment is computed based on state-by-state data from providers’ reasonable charges subject to a national ceiling on the payment.16

Similarly for equipment that beneficiaries “rent-to-own,” the statute establishes that Medicare pays for the equipment as a rental during a period of medical necessity not to exceed 13 months. The statute also specifies the payment amount for each rental month and instructs the Secretary on how to determine applicable fee schedule amounts.17 With respect to rental equipment, Congress explicitly requires the Secretary to apply the payment rules under §1834 (a) in the CBAs. Section 1847 requires the Secretary to ensure that it pays for oxygen and rental DME according to the rules under §1834 (a).

We believe that there is no authority in these statutes for CMS to create bundled payments for DME under competitive bidding. These statutes clearly limit CMS’ authority to use the SPA as the payment basis for DME, but CMS does not have the authority to change the payment rules for equipment. We ask that CMS refrain from issuing a proposed rule to use competitive bidding to create a bundled Medicare payment system for items of DME.

B. Current prospective payment systems or bundled Medicare payment models are unworkable in the context of payment for DME or enteral equipment, nutrients and supplies.

AAHomecare believes that the type of bundling CMS is proposing would be so complex that it could not be implemented under the DMEPOS benefit without a comprehensive analysis of the costs to furnish equipment to a chronically ill patient with a progressive condition. CMS must understand the unpredictability of product need that can occur throughout the progression of a beneficiary’s disease or any complications that arise from his or her disability as they consider implementing a bundled payment system in DMEPOS. In addition to different equipment needs, each beneficiary will have a different level of utilization and require higher or lower service intensity depending on his or her condition.

CMS’ proposal to bundle payment for equipment and supplies appears to solely focus on the equipment bundle and not on the needs of the patient using the equipment. Although CMS appears to be modeling the bundled payment for DME and enteral therapies on existing Medicare PPS methodologies and the home oxygen benefit, we believe this model will not work as intended.

1. It is impossible to divorce an individual’s need for DME and enteral equipment, nutrients, or supplies from his medical condition and the progression of his disease or disability.

16 §1395m (a) (2) (A) & (B)
17 §1395m (2) (7)
Payment under the home health or skilled nursing facility PPS is based on a comprehensive, standardized assessment of the beneficiary’s condition and the services and level of care he or she will need. The PPS methodology includes criteria to identify patients who may be low- or high-utilization outliers and adjusts the payment amount to account for these individuals. This methodology is also based on extensive data collection and analysis that was carried out by Medicare over many years prior to implementing PPS. Thus, while the PPS payment ties together a bundle of services and certain equipment and supplies that a beneficiary might use during an episode of care, the bundle, and most importantly, payment for the bundle, is based on an assessment of the beneficiary’s condition, which determines what bundle of services a beneficiary is most likely to need and their level of intensity.

For home health, CMS was able to create and implement a PPS because it had the data to know the different factors that influenced how patients fared under an episode of care. The data collection was the basis for the OASIS tool which serves as the foundation for establishing payment that ties back to the patient’s condition and the care he or she needs.

In contrast, we believe that CMS has virtually no information on the factors that influence an individual patient’s length of need for a specific type of equipment or what factors might trigger his or her progression to the next level of equipment and services. For respiratory devices and wheelchairs in particular, disease progression often means that the beneficiary goes from a lower-level device to a higher-level device in another HCPCS code. The beneficiary must then meet new medical necessity criteria to qualify for the higher-level device used to treat the disease progression. We believe CMS lacks the data to define how or when these transitions should occur. The current local coverage determinations (LCDs) are equipment/service specific and would need to be revised in order to reflect coverage based on the specific needs of a patient even if his or her level of utilization of equipment or supplies is more or less than that of the average patient with the same condition.

To the extent that CMS may model the proposed bundled payment for DME on the Medicare oxygen benefit, the model does not work for many of the same reasons described above. As we noted, it is impossible to separate an individual’s need for equipment from his or her medical condition and the progression of his disease or disability. DME is used to treat many chronic conditions, each of which follows its own clinical trajectory. An individual’s unique response to his disease or disability can strongly influence how quickly the condition progresses. At the start of care, there is no standardized way to assess how a beneficiary will fare over the course of treatment.

The multitude of variables that must be factored into an equipment and service bundle for DME and enteral products, and as a result, payment for the bundle, should be contrasted with the information that was available when the Medicare home oxygen benefit was designed 25 years ago. At that time, the patient demographic was believed to be homogenous. Oxygen patients would use oxygen for the remainder of their lives. Generally, these patients were confined to their homes, and most of them would use portable oxygen primarily for mobility within the home. This patient profile was the driver of the original bundled Medicare home oxygen payment. Twenty-five years ago, a continuous, monthly, bundled payment for oxygen compensated the provider for ongoing service to a beneficiary with a limited life expectancy and ensured that the beneficiary’s service needs were continuously met for the remainder of his or her life. Progression of the beneficiary’s disease might dictate a higher oxygen flow rate, but the provider would be compensated for the higher-level equipment because of the continuous rental methodology.
When the oxygen payment was designed, the beneficiary’s medical condition and the payment for oxygen were closely aligned. This is not the case with other types of DME and enteral equipment, nutrients, or supplies given the many different conditions, all with different trajectories, that can be treated with the same type of equipment.

1. **Paying for DME or enteral products under a continuous bundled rental payment would not be more advantageous to beneficiaries compared with the current rent-to-own or capped rental payment methodologies.**

Establishing a bundled payment for DME and enteral products would not be helpful to a beneficiary. In our members’ experience, beneficiaries typically do not like to receive explanations of benefits (EOBs) for bundled items because they cannot match the EOB to the care they received. Beneficiaries prefer to be billed for the actual items they receive. More importantly, beneficiaries would encounter serious disadvantages including the loss of access to high-end or specialized equipment, higher copays, and difficulty in changing providers.

   a) **Some beneficiaries may have difficulty accessing care.**

   Under a bundled payment system, beneficiaries who cost more to treat due to their medical condition may find it more difficult to access care. For example, providers may find that beneficiaries who need long-term rentals with low service and utilization needs are easier to treat because their conditions are stable or they have caregivers that allow them to function with less expensive equipment or services. In contrast, beneficiaries who have short-term and/or acute conditions that require more intensive services will be more difficult to treat and could have a harder time accessing care. This occurred when CMS transitioned to the SNF PPS. Patients with high service needs such as wound care patients had a more difficult time finding a SNF that would accept them than did patients with more routine care needs. 18 The only way to address this issue is to apply adjustment factors to account for the patient’s condition and to front load payments in order to fully compensate providers who serve short-term and acutely ill patients.

   b) **Beneficiaries who need to rent equipment for a long time will pay more in copays.**

   A bundled payment would also adversely affect beneficiaries financially. The cost burden would shift to beneficiaries with long-term rentals who would subsidize the care of short-term and acute service intensive conditions. As stated above, one way to offset the impact of this cost shift for beneficiaries is to ensure that payments are front loaded so that providers are fully compensated for servicing short-term patients.

   c) **Bundling would not eliminate the need for patients to requalify for equipment when they change providers.**

   Beneficiaries will still need to re-establish medical necessity for base equipment and any necessary supplies when they change providers. In addition, under the face-to-face rule, providers must obtain a written order for the item and documentation that an appropriate face-to-face encounter between the

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beneficiary and a physician or qualified non-physician practitioner has occurred before delivering the item to the beneficiary. CMS has interpreted this requirement to apply every time a beneficiary changes providers. This means that beneficiaries who change providers as a result of competitive bidding, or for any other reason, must have a face-to-face encounter with a physician (or other non-physician practitioner recognized under the regulations) in order to receive equipment from a new provider. The provider must, in turn, receive documentation that the face-to-face encounter occurred and a written order for the item before delivering the item to the beneficiary. This means that beneficiaries cannot change providers unless: 1) they are prepared to visit their doctor for a determination that the medical equipment they use continues to be necessary, and 2) medical necessity for the item is fully documented. This latter point means that if an LCD or NCD requires a specific test, the beneficiary must be able to show documentation of a valid test or be prepared to be retested, and in some cases to pay for the test or their medical supplies out of pocket. It is important to note that providers often have difficulty in obtaining medical documentation from physicians prior to being able to provide beneficiaries with their needed equipment.

2. Are there reasons why beneficiaries need to own expensive DME or enteral nutrition equipment rather than use that equipment as needed on a continuous monthly basis?

We would like to note that many beneficiaries who receive enteral therapies do not actually require equipment. While it may not be necessary for a beneficiary to own DME or the equipment used in enteral therapies, CMS’ proposal to bundle all equipment and services a beneficiary may need during a period of medical necessity is not favorable to beneficiaries for the reasons we stated above. Disadvantages to beneficiaries under bundling would outweigh any advantages CMS might see.

3. Would there be any negative impacts associated with continuous bundled monthly payments for enteral nutrients, supplies, and equipment or for certain DME? If so, please explain.

We do not support bundled payments for any DME. If bundled payments were implemented for enteral nutrients, supplies, and equipment we do believe there would be a negative impact. The most important factor to consider is the individual patient. Patient-centered care is a very important aspect in the health care industry today and care should be customized to reflect an individual patient’s needs and choices. By focusing on the patient, one can recognize that each patient is different and will have different needs and preferences. In particular, with enteral nutrient supplies, the degree of need for these supplies varies greatly patient to patient.

4. Certain DME items such as speech generating devices and specialized wheelchairs may be adjusted or personalized to address individual patient needs. Would payment on a bundled, continuous rental basis adversely impact access to these items and services? If so, please provide a detailed explanation regarding how this method of payment would create a negative impact on access to these items and services or other items and services currently subject to competitive bidding.

We do not support bundled payments for DME, but if implemented, it would depend on the method used for bundling payments for these items. As stated above, the most important factor to consider is the individual patient. By focusing on an individual patient, one can recognize that each patient is different and will have different needs and preferences. Specialized wheelchairs are a very good example of tailoring a piece of equipment to a patient. Some patients may need a more expensive
wheelchair because their physician determined that the additional components that may come with the more expensive wheelchair could provide that patient with greater independence and allow them to enjoy their life more. In addition, some patients may not need all the “bells and whistles” on their wheelchair, and would be satisfied with a basic type of wheelchair. If the condition that required the patient to need the wheelchair in the first place changed, then a reevaluation would need to be made to determine what type of equipment would best suit the individual patient based on the change in condition. CMS must consider the unpredictability of a patient’s condition as they consider how to change how providers are reimbursed for their equipment. Below is an example of a patient’s progression through an illness that required a change in the type of equipment needed.

An individual patient with ALS was initially diagnosed with Benign Fasciculation Syndrome (BFS) (781.0) in their right upper and lower extremity. Over the next six months their function declined such that they were no longer independent in ambulation, even with a gait aid, and a manual wheelchair was prescribed. Within three months the individual patient was unable to propel the manual wheelchair safely, timely, or independently and a Group 2 power wheelchair with a captain seat was prescribed as the ICD-9 code did not fall under the purview of a neurological condition, myopathy, or congenital skeletal deformity for a Group 3 base and rehab seating was not provided as the individual did not have a covered ICD-9 code.

Fifteen months after the beneficiary received the Group 2 power wheelchair they were unable to sit in it safely or operate the standard joystick due to continued loss of function. They were reevaluated by the neurologist and their primary diagnosis was changed from BFS to Amyotrophic Lateral Sclerosis (335.20). They were evaluated for a Group 3 power wheelchair with power seating functions, wheelchair seating, and appropriate wheelchair options and accessories.

5. If payment on a capped rental, rent-to-own basis or lump sum purchase basis is maintained for certain items under the competitive bidding program, should a requirement be added to the regulations specifying that the provider that transfers to the equipment to the beneficiary is responsible for all maintenance and servicing of the beneficiary owned equipment for the remainder of the equipment’s reasonable useful lifetime with no additional payment for these services? The cost of such mandatory provider warranty would be factored into the bids submitted by providers and the payment amounts established based on the bids for the items.

No. The rationale for this type of policy is that providers will have been fully compensated for the equipment, supplies, and necessary routine and non-routine services at the conclusion of a rental period. This reasoning does not take into account the service needs of beneficiaries and incorrectly assumes that Medicare pays only for equipment under the DME benefit. For example, in order to furnish emergency services and make unscheduled service calls, a provider must have the capacity to furnish those services whenever the beneficiary needs them. In other words, non-routine services must be available whether or not a beneficiary requests them. It is impossible for a business to provide emergency services, which by definition must be rendered on demand, without incurring overhead and other operating costs to ensure that the services are available. We find it hard to understand how CMS could expect providers to furnish these important ongoing support functions without any compensation.

CMS implemented this policy for oxygen and oxygen equipment after rental payments cap in month 36. This policy has proven to be so burdensome that many oxygen providers have been forced to close their
business altogether, forcing beneficiaries to find new providers. CMS recently instructed its contractors to begin a new period of continuous need for beneficiaries whose oxygen provider went out of business. CMS’ issuance of guidance on “abandoned” oxygen patients on the transition of these beneficiaries to new providers acknowledges that the policy has resulted in significant loss of access for beneficiaries.

In 2006, Morrison Informatics performed a comprehensive analysis of the costs to providers of furnishing home oxygen to Medicare beneficiaries. They found that providers’ acquisition costs for oxygen equipment accounted for only 28 percent of the costs of providing service to Medicare beneficiaries. Providing oxygen to beneficiaries also requires cleaning and preparing equipment, delivering and setting it up, training, and other costs and overhead. Together these costs accounted for 72 percent of the costs of providing services to beneficiaries. Although the figures in the report are dated, providers’ costs, especially fuel costs, have risen considerably since the report was published such that the ratios of direct and indirect overhead costs to the acquisition price of the equipment are still valid today. These ratios of costs also apply to DME and enteral therapies.

Suppliers need to be compensated for the direct labor and other costs of providing customer service and emergency services to beneficiaries and the indirect costs they incur in making those services continuously available. Likewise, providers must be compensated for the costs of remaining available to beneficiaries to make adjustments to their equipment or trouble shoot issues by phone.

Eliminating a fee for service benefit for maintenance, servicing, repairs, adjustments, and personalization of DMEPOS will create significantly more issues for beneficiaries if providers discontinue operations in a specific geographic area. CMS is currently struggling to help “abandoned” oxygen patients receive oxygen contents, supplies, and maintenance and has created a rule to address this access issue.

a) If such a requirement was established, should the term maintenance and servicing be defined to include all necessary maintenance, servicing and repairs that are currently paid for separately under the Medicare program in addition to any additional adjustments or personalization of the equipment that may be needed once title transfers to the patient? We believe the requirements may be necessary to safeguard the beneficiary and access to necessary services related to beneficiary owned DME.

Such a definition would be insufficient to safeguard beneficiary access to care. Beneficiary access is protected when the provider servicing the beneficiary has a viable business model that provides the revenue necessary for the provider to remain operational and meet the requirements of accreditation and the Medicare provider and quality standards. The model CMS is describing would not protect beneficiaries because most providers, even large providers, cannot provide services without compensation for what would amount to four of the five years of the equipment’s useful lifetime. As we

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20 Ibid.
22 Ibid.
noted above, experience with this type of bundled reimbursement for oxygen has proved to result in loss of access to needed care for beneficiaries.

6. Would payment on a bundled, continuous rental basis for certain items adversely impact the beneficiary’s ability to direct their own care, follow a plan of care outlined by a physician, nurse practitioner or other medical provider (for example, occupational, physical or speech therapist), or provide for appropriate care transitions? If so, please explain.

It is possible that a bundled, continuous rental basis for certain items could adversely impact a beneficiary’s ability to direct their own care, follow a plan of care outlined by their physician, nurse practitioner or other medical provide. A patient’s medical condition can change day-by-day, month-by-month, and even hour-by-hour in some cases. Depending on the patient’s condition and what medical equipment they are currently using, a physician may decide they no longer need one product because another one would work better. That new product could be more expensive than the previous one used, but if it improves a patient’s medical condition that should be of the utmost importance when determining reimbursement rates. CMS should consider the costs of treating a patient’s condition instead of the cost of DME alone. If a more expensive piece of equipment will reduce the need for other potentially more expensive treatments for a patient’s medical condition, providers should be reimbursed fairly for providing that potentially life-saving equipment to an individual patient.

7. What are the advantages or disadvantages for beneficiaries and providers of bundled bidding and payments for enteral nutrients, supplies, and equipment or DME?

We do not believe there would be any advantages to beneficiaries in a bundled payment system. Some possible advantages for providers include: less complicated claims submission due to less adjudicated lines (this is inconsequential as this is automated with Medicare claims submission). In addition, there would be less complicated EOBs due to less adjudicated lines (again, this is inconsequential as most Medicare payment application is automated).

The disadvantages to beneficiaries would be that bundled payments may decrease timely availability of expensive items as providers may not stock expensive items if those items are unprofitable by themselves or if the inclusion of “one more add-on” tips reimbursement negatively for a specific beneficiary. A beneficiary would not be able to easily access certain specialized accessories. For example, if there is a manual wheelchair bundle which includes a manual wheelchair and common accessories, the beneficiary may have received a manual wheelchair in month one. In month three of their period of medical necessity it could be determined the patient urgently requires brake extensions to safely use their wheelchair. A physical therapist may have determined a specific brand/model of brake extensions provides some functional advantage for the specific patient. The provider of the wheelchair may only stock a different brand/model of brake extensions which offers a lower level of utility for this specific beneficiary. The beneficiary may have to switch wheelchair providers or wait for some period of time to receive the specific brand/model of brake extension. Bundled payments may also decrease the responsiveness of providers when filling add-on orders within a bundle because the beneficiary will be required to receive the additional items within the bundle from the current bundle provider until their next rental month begins. It is easy to imagine providers being very responsive to initial orders in a bundle but less responsive to add-on orders in a bundle.
The disadvantages to providers would be that they will be required to develop relationships with a wider range of manufacturers because they will be responsible for providing everything in a product category (this is largely true today in CBAs, but not in non-CBA markets). Providers may have to transfer existing beneficiaries to other providers. Many contract providers today rely on other contracted providers to fill orders for uncommon or niche products. As an example, a CPAP provider may not stock and have immediately available a specific make/model/size of a specific CPAP mask requested by a physician or beneficiary. In the current scheme, the beneficiary may be referred to another contracted provider who stocks that particular item to facilitate timely access to the product. In a bundled scheme, the beneficiary will either have to wait until their current provider can fill the order or switch providers for their entire CPAP device and supplies. If there is a single coverage criteria for the entire bundle (rather than individual items within a bundle) there could be a shift in demand to more high cost items within a bundle in the future. For example, physicians may order bi-level (instead of lower cost CPAP) more to treat obstructive sleep apnea in the future if there is a single CPAP coverage criteria and not individual coverage criteria for CPAP and bi-level.

8. Should competitive bidding programs utilizing bundled payments be established throughout the entire United States so that all beneficiaries are included under programs where providers have an obligation to furnish covered items and all related items and services?

If CMS decides to implement a bundled payment system in the competitive bidding program, we would recommend testing the bundled payment system in a demonstration in one CBA using a bundled payment system since bundled payments have never been used before within the DME industry. The purpose of this demonstration would be to identify the costs and benefits to providers and beneficiaries prior to implementing a new payment system in the durable medical equipment industry. CMS would also need to implement equitable quality standards to ensure beneficiary access to quality of care. Providers would have a difficult time furnishing covered items and services to beneficiaries if they are unable to afford to provide quality products to their customers if the reimbursement rates remain as low as they have in Round 1 and Round 2 of competitive bidding. Providers will have difficulty providing quality products to beneficiaries because they will be unable to afford to purchase the products and sell them at reasonable rates.

9. Is a continuous bundled monthly payment used by commercial payers of state Medicaid programs for enteral nutrients, supplies and DME and do these approaches inform the potential new payment arrangement for Medicare?

To our knowledge, there are no commercial or government payers that bundle DME in the way CMS is proposing to do so. Some private sector payers and state Medicaid programs employ a per diem payment for enteral equipment and some supplies, but purchase the formula and certain supplies separately. The formula must be paid for separately because a patient’s caloric needs and formula type can vary greatly. However, even if such bundling were to occur, it is not possible to make direct comparisons between Medicare and other payers given the fundamental differences in how these payers do business compared to Medicare. Overall, it is more expensive to do business with Medicare than it is to do business with other payers.

There are extensive differences between these payers and the Medicare program on how promptly they pay claims, the level of medical necessity documentation they require, and how the audit process works. The General Accountability Office (GAO) compared differences between the Veterans Administration
(VA) and Medicare oxygen payments and concluded that, while Medicare paid more for oxygen, the cost of doing business with Medicare was 30 percent more for providers than that of doing business with the VA. The GAO concluded that difference was attributable primarily to Medicare billing and documentation rules and its claims processing procedures.23

There is also a significant difference between doing business with Medicare and internet or cash sales. The Office of Inspector General for Health and Human Services (OIG) recognized this point in an advisory opinion on whether a provider could charge a Medicare beneficiary substantially in excess of the amount it charges a “cash and carry” patient. The OIG concluded that the higher charges to Medicare could be justified if they were directly and solely attributable to the higher cost of doing business with the program.24 Appendix 3 shows how much more complicated it is for providers to process a Medicare order compared with cash sales and internet orders for the same item. Finally, commercial payers generally do not audit for medical necessity. Instead, they review whether the provider followed the payer’s payment rules. Medical necessity is established by the physician’s order.

Further, unlike the competitive bidding program under Medicare, commercial payers typically guarantee the volume of business a provider will receive, or enter into an exclusive contract with the provider. Consequently, any price concessions a provider makes are based on arms-length negotiations where the provider is informed on what doing business with the payer will entail.

III. CONCLUSION

AAHomecare appreciates the opportunity to submit these comments and reiterates our commitment to working with CMS in order to arrive at a workable payment system for durable medical equipment. Please feel free to contact me should you have any questions or if I can be of any assistance.

Sincerely,

Thomas Ryan
President and CEO

23 GAO, Medicare: Comparison of Medicare and VA Payment Rates for Home Oxygen, HEHS -97- 120R (1997)
APPENDIX

Table of contents

Appendix 1

Appendix 2

Appendix 3
American Association for Homecare Comparison of DMEPOS Suppliers’ Workflow to Process Medicare Order vs. Internet or Cash Sal, available at: https://www.aahomecare.org/
## Average Fuel Cost by State – US Dept. of Energy

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### Medicare Order Process

1. **Company receives order from prescriber**
   - Company verifies:
     - prescriber is licensed
     - prescriber is enrolled in PECOS
     - customer does not have same or similar equipment already
     - customer has completed an office visit with the prescriber
     - office visit notes meet all Medicare requirements
     - office visit notes are signed by a doctor
     - prescription meets all Medicare requirements
   - If any item cannot be verified, the customer declines the order or pays in full
2. **Company enters order**
3. **Company makes delivery**
4. **Company educates customer on use of equipment**
5. **Company collects all completed paperwork from customer**
6. **Company bills Medicare**
   - Medicare pays claim
   - Medicare denies claim and does not pay
     - Company appeals decision
     - Customer keeps equipment
     - Company collects all patient files and sends copies to Medicare
     - Company waits 60 days for Medicare’s decision to pay or not
   - Medicare audits claim and does not pay
     - Company appeals decision
     - Customer keeps equipment
     - Company collects all patient files and sends copies to Medicare
     - Company waits 60 days for Medicare’s decision to pay or not
7. **Company receives Medicare payment**
8. **Company bills other insurance for balance and customer for co-pay**
9. **Order complete**

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### Retail Order Process

1. **Customer selects product**
2. **Store gets prescription if needed**
3. **Store verifies prescription meets state requirements**
4. **Customer pays**
5. **Order Complete**

### Online Order Process

1. **Customer selects product**
2. **Company gets prescription if needed**
3. **Company verifies prescription meets state requirements**
4. **Customer pays**
5. **Company ships product**
6. **Order Complete**

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

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American Association for Homecare
Caring that Feels Right at Home
www.aahomecare.org