Testimony of Tom Ryan

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Before the Subcommittee on Health

House Energy and Commerce Committee

On

Legislative Proposals to Support Patient Access to Medicare Services

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Chairman Griffith, Ranking Member DeGette, and members and staff of the House Energy and Commerce Subcommittee on Healthcare, my name is Tom Ryan. I am president and CEO of the American Association for Homecare (AAHomecare), which is the national association for durable medical equipment suppliers and manufacturers. Prior to my position at AAHomecare, I was president and CEO of Homecare Concepts in Long Island, NY for 30 years.

I would like to thank the Subcommittee for holding this important hearing to examine the legislation to protect Medicare beneficiaries' access to medical services. I am pleased to share AAHomecare's position and my personal experience on the legislation before the committee today. Specifically, I will provide testimony and support for H.R. 1703, H.R. 2005, and H.R. 2902.

AAHomecare is the national trade association for home medical equipment service providers, manufacturers and other stakeholders in the homecare community. AAHomecare members serve the medical needs of the millions of Americans who require supplemental oxygen therapy, mobility assistive technologies (standard and complex wheelchairs), hospital beds, diabetic testing and medical supplies, inhalation drug therapy, home infusion and other home medical products, services and supplies. Nearly 80 percent of AAHomecare members are small businesses.

Home medical equipment is a vital component of the continuum of care, improving patient quality of life and outcomes. It is a fundamental component to controlling health care costs by keeping beneficiaries in the most cost-effective and patient-preferred setting—their homes—rather than providing acute care in emergency departments and extended care institutional settings.

I will provide the Subcommittee with reasons why the association supports these important bills and the need for Congress and the Administration to protect access for durable medical equipment in Medicare.

Before addressing these important bills, I wanted to call to the attention of the Subcommittee the recently announced plans by the Centers for Medicare and Medicaid Services (CMS) to move forward with the next round of competitive bidding for DMEPOS items. We have a number of very serious concerns about CMS' plan.

First, we believe CMS' plan to include medical supplies such as ostomy and urological supplies is directly contrary to Congress' intent to not include these items as being eligible for inclusion in the competitive bidding program.

Second, CMS' plan to include continuous glucose monitors (CGMs) and change their "payment category" to significantly reduce the ceiling against which bids must be submitted will directly threaten not just beneficiary access, but will thwart the development of new innovative technology that helps Americans manage chronic health conditions safely in their homes.

Third, CMS' plan to dramatically reduce the number of companies to less than ten each – to provide CGMs, ostomy supplies, urological supplies and other products - will not only directly

harm small businesses across the entire country, but will also undermine the nationwide home medical equipment infrastructure that enables patients to be cared for in their homes.

Lastly, CMS' changes to the bid program will dramatically and artificially reduce payment amounts to unsustainable levels, leaving very few DMEPOS suppliers to service not just Medicare beneficiaries, but all Americans.

H.R. 1703

On December 15, 2016, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) released a policy that prohibited upgrades for titanium wheelchairs, which prevents suppliers from billing the beneficiary for the difference between what Medicare pays for a more typical/standard wheelchair and an upgraded wheelchair. As a result, the only avenue to obtain titanium and carbon fiber wheelchairs is to pay for the entire wheelchair out of pocket and for the DME supplier to file a non-assigned claim to CMS for partial reimbursement. This is prohibitive to many beneficiaries and has detrimentally affected access to titanium and carbon fiber wheelchairs. It also runs contrary to standard Medicare policy that encourages suppliers and other providers to accept assignment and submit assigned claims.

Medicare beneficiaries should have the choice to pay for a titanium or carbon fiber upgrade to their manual wheelchair. On February 27, 2025, Representatives John Joyce and Vern Buchanan introduced the Choices for Increased Mobility Act of 2025 (H.R. 1703). Representative Kim Schrier is a cosponsor of this important legislation. The legislation would create two new wheelchair codes and enable upgrades within a code removing the current obstacles in place and offering key benefits to end users at no additional cost to CMS.

Individuals with disabilities should have the right to choose and cover the costs of specialized materials for their wheelchair. Restoring this option would not remove medical necessity requirements for the wheelchair itself and would not result in any additional costs to Medicare. CMS should permit individuals to make the choice as to whether a titanium or carbon fiber chair would be best for them in terms of increased mobility and quality of life. The Choices for Increased Mobility Act will improve access to titanium/carbon fiber wheelchairs in Medicare.

I would like to thank Representatives Joyce and Buchanan for introducing this important bill, as well as Health Subcommittee member Schrier for cosponsoring the legislation. AAHomecare appreciates the bipartisan work that this Committee did to advance this policy last Congress and continues to strongly support this legislation and urges its passage.

H.R. 2005

On October 31, 2014, CMS released a final rule which established the methodology for making national price adjustments to the fee-for-service payments of specific DME items. This methodology applies pricing derived from highly populated CBAs to all areas of the country and fails to consider the unique attributes of health care in rural America, which have distinct cost differences from their urban counterparts, and are stripping communities of DME resources.

On January 1, 2016, the first phase of the two-part reimbursement adjustment for suppliers serving patients outside of CBAs took effect. On July 1, 2016, the prices were fully phased in, slashing Medicare reimbursement by over 50% on average.

Due to mounting concerns about the impacts of cost-cuts on patient access to care, especially in non-CBAs and rural America, Congress intervened and included a provision in the 21st Century Cures Act to extend the reimbursement rates in effect on January 1, 2016 through December 31,

2016. This provided retroactive relief to DME suppliers, but on January 1, 2017, the full reimbursement cut went back into effect.

At the urging of Congress, patients, and suppliers, CMS issued an Interim Final Rule on May 9, 2018, that provided emergency relief to rural areas until the end of 2018 at the 50/50 blended reimbursement rate. On November 1, 2018, CMS finalized the ESRD/DMEPOS rule which extended the rural relief until the end of 2020. The 2020 final DMEPOS rule extended the 50/50 blended reimbursement rate indefinitely.

As a result of the increased cost and supply chain issues, Congress provided additional DME non-CBA relief in the 2022 Omnibus Appropriations bill. This provision provided a 75/25 blended rate for non-rural, non-CBAs throughout 2023. In 2024, the relief expired and cuts of over 30% went into effort.

Congress provided relief in the 2020 CARES Act and 2022 Omnibus bill for non-rural, non-CBAs until the end of 2023. This relief was vital to protecting Medicare beneficiaries' access to the home medical equipment they need. This relief has expired and cuts of over 30% are now in effect. A policy that reimburses suppliers in non-competitive bid areas the exact same amount reimbursed to suppliers that bid in competitive bid areas under exclusive contracts continues to be unfair and detrimental to timely beneficiary access. Since the inception of competitive bidding, it is estimated that over 30% of traditional DME companies nationwide have either closed or no longer service Medicare patients due to these unsustainable payment cuts.

On March 10, 2025, Representatives Mariannette Miller-Meeks, Paul Tonko, Randy Feenstra, and Jimmy Panetta introduced H.R. 2005, which provides a 75/25 blended rate relief for DME items for non-bid, non-rural areas until the end of 2025. In December 2023, a measure to extend

this relief (H.R. 5555) was approved by the House Energy & Commerce Committee. Similar Senate legislation, S. 1294, was approved by the Finance Committee in November 2023.

I will note for the committee that the timeframe for the relief in H.R. 2005 is calendar year 2025. AAHomecare looks forward to working with the bill sponsors and the House Energy and Commerce Committee to update the timeline for the relief as the bill moves through the legislative process.

I would like to thank Representatives Miller-Meeks, Tonko, Feenstra, and Panetta for introducing H.R. 2005, as well as Health Subcommittee members Representatives Harshbarger, Langworthy, and Carter for cosponsoring the legislation. AAHomecare strongly supports this legislation and urges Congress to pass it as soon as possible.

H.R. 2902

On April 10, 2025 Representatives David Valadao, Julia Brownley, Adrian Smith, and Gabe Evans introduced the Supplemental Oxygen Access Reform Act of 2025 (H.R. 2902) to address the well-documented patient access barriers to accessing supplemental oxygen, particularly liquid oxygen. The legislation would lock in the substantial savings Medicare has already obtained during previous rounds of competitive bidding and create a new payment methodology for liquid oxygen. Moreover, it would address the ongoing concerns about fraud and abuse by leveraging technology-based solutions – a national standardized electronic template completed by the prescriber and shared electronically with both the provider and CMS. This policy will greatly reduce fraud and abuse along with the cost burden of audits for both CMS and providers. Moreover, the legislation would establish patient protections as well. It would also recognize the importance of patient access to respiratory therapists services, which are often necessary –

especially when they are given a new oxygen prescription – to support individuals' care, by reimbursing for these services.

Since 2011, supplemental oxygen has been part of Medicare's DMEPOS Competitive Bidding Program, resulting in significant decreases in payments for oxygen equipment and supplies. While we appreciate that payment reductions have produced Medicare savings, they have also led to serious barriers to patients accessing medically necessary oxygen equipment, supplies, and services. The rates for liquid oxygen are far below the cost suppliers incur to fill physician prescriptions. Under the current reimbursement methodology, many individuals who require supplemental oxygen do not receive the types of oxygen systems that are needed. As a result, these individuals are at high risk for worsening health, avoidable emergency room visits, and hospitalizations.

It is critically important to stabilize the Medicare supplemental oxygen benefit to provide beneficiary access to the equipment that best addresses their medical needs. Individuals with the most significant oxygen needs cannot use small, portable oxygen concentrators (known as POCs) because they do not provide high flow rates. Instead, these people are currently dependent on large tanks of compressed, gaseous oxygen. These large tanks of oxygen are heavy, bulky, and may provide only a couple of hours of oxygen at a time. People who have any sort of mobility issues struggle to get around with even one of these large tanks. Consequently, those individuals who need high flow rates often end up effectively housebound.

The SOAR Act would bring significant health and well-being benefits to the 1.5 million individuals living with COPD, heart disease, pulmonary hypertension, pulmonary fibrosis, people awaiting lung transplants and other advanced respiratory diseases who rely on

supplemental oxygen. Oxygen therapy can decrease mortality, reduce shortness of breath, and increase exercise capacity.

I would like to thank Representatives Valadao, Brownley, Smith, and Evans for introducing H.R. 2902, as well as Health Subcommittee members Representatives Balderson and Dingell for cosponsoring the legislation. AAHomecare, as well as 26 patient, physician, health care professional, and supplier organizations strongly support this legislation. We urge Congress to pass this important legislation as soon as possible.

Conclusion

I would like thank Chairman Griffith, Ranking Member DeGette, and Subcommittee members for this important hearing. As I mentioned, home medical equipment is a vital component of the continuum of care and is a fundamental component to controlling health care costs by keeping beneficiaries in the most cost-effective and patient-preferred setting—their homes. H.R. 1703, H.R. 2005, and H.R. 2902 will help protect Medicare beneficiaries' access to home medical equipment they need. AAHomecare looks forward to working with the Subcommittee as these bills move through the legislative process. I look forward to answering any questions you may have.