A Government Divided: The Good, The Bad, and The Helpful

1

Industry focuses for 2023

Grassroots Activities and Opportunities

- Meetings with Incoming Congressional Freshman - 80+
- Build relationships with new and returning Congressional members and staff on Key Committees
- GAP (Grassroots Accountability Project) we need you!
- Press Opportunities
- August of Action!
- 2024 Elections are just around the corner!

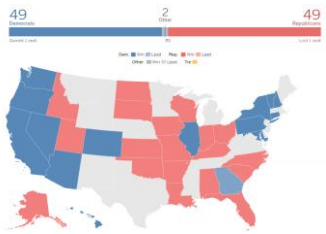
2

2022 Midterm Election

A divided government can be more productive than you think

3

Senate



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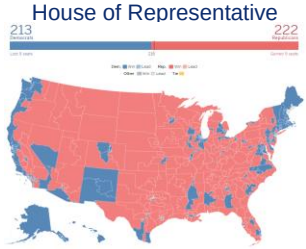
House of Representative



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Michigan Congressional Delegation
118th Congress

Office	Name	Party	Date assumed office	Date term ends
U.S. House Michigan District 1	Jack Bergman	Republican	January 3, 2017	January 3, 2025
U.S. House Michigan District 2	John Moolenaar	Republican	January 3, 2023	January 3, 2025
U.S. House Michigan District 3	Hillary Scholten	Democratic	January 3, 2023	January 3, 2025
U.S. House Michigan District 4	Bill Huizenga	Republican	January 3, 2023	January 3, 2025
U.S. House Michigan District 5	Tim Walberg	Republican	January 3, 2023	January 3, 2025
U.S. House Michigan District 6	Debbie Dingell	Democratic	January 3, 2023	January 3, 2025
U.S. House Michigan District 7	Elissa Slotkin	Democratic	January 3, 2023	January 3, 2025
U.S. House Michigan District 8	Dan Kildee	Democratic	January 3, 2023	January 3, 2025
U.S. House Michigan District 9	Lisa McClain	Republican	January 3, 2023	January 3, 2025
U.S. House Michigan District 10	John James	Republican	January 3, 2023	January 3, 2025
U.S. House Michigan District 11	Haley Stevens	Democratic	January 3, 2019	January 3, 2025
U.S. House Michigan District 12	Rashida Tlaib	Democratic	January 3, 2023	January 3, 2025
U.S. House Michigan District 13	Shri Thanedar	Democratic	January 3, 2023	January 3, 2025

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Michigan Senate Delegation
118th Congress

Office	Name	Party	Date assumed office	Date term ends
U.S. Senate Michigan	Gary Peters	Democratic	January 3, 2015	January 3, 2027
U.S. Senate Michigan	Debbie Stabenow	Democratic	January 3, 2001	January 3, 2025

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New Committee Assignments
House Ways & Means

House Republicans tapped ten new members to join the Ways and Means Committee this year

These committee members have significant influence over the tax code, trade policy, Medicare, Social Security and social services programs

Rep. Mike Carey (R-OH)
Rep. Randy Feenstra (R-IA)
Rep. Michelle Fischbach (R-MN)
Rep. Brian Fitzpatrick (R-PA)
Rep. Nicole Malliotakis (R-NY)
Rep. Blake Moore (R-UT)
Rep. Michelle Steel (R-CA)
Rep. Greg Steube (R-FL)
Rep. Claudia Tenney (R-NY)
Rep. Beth Van Duyne (R-TX)

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Ways & Means Committee

Majority	Minority
•Jason T. Smith, Missouri, Chair •Vern Buchanan, Florida, Vice Chair •Adrian Smith, Nebraska •Mike Kelly, Pennsylvania •David Schweikert, Arizona •Darin LaHood, Illinois •Brad Wenstrup, Ohio •Jodey Arrington, Texas •Drew Ferguson, Georgia •Ron Estes, Kansas •Lloyd Smucker, Pennsylvania •Kevin Hern, Oklahoma •Carol Miller, West Virginia •Greg Murphy, North Carolina •David Kustoff, Tennessee •Brian Fitzpatrick, Pennsylvania •Greg Steube, Florida •Claudia Tenney, New York •Michelle Fischbach, Minnesota •Blake Moore, Utah •Michelle Steel, California •Beth Van Duyne, Texas •Randy Feenstra, Iowa •Nicole Malliotakis, New York •Mike Carey, Ohio	•Richard Neal, Massachusetts, Ranking Member •Lloyd Doggett, Texas •Mike Thompson, California •John B. Larson, Connecticut •Earl Blumenauer, Oregon •Bill Pascrell, New Jersey •Danny K. Davis, Illinois •Linda Sánchez, California •Brian Higgins, New York •Terri Sewell, Alabama •Suzan DelBene, Washington •Judy Chu, California, Vice Ranking Member •Gwen Moore, Wisconsin •Dan Kildee, Michigan •Don Beyer, Virginia •Dwight Evans, Pennsylvania •Brad Schneider, Illinois •Jimmy Panetta, California

9

New Committee Assignments
House Energy & Commerce

House Republicans added nine new members to the powerful Energy and Commerce Committee, including a handful of members with significant health policy experience.

This committee has broad jurisdiction over telecommunications, consumer protection, environmental quality, energy policy and interstate and foreign commerce. It's also one of the main health care committees in the House, with jurisdiction over Medicaid, mental health, substance abuse, health insurance, medical research, the FDA and pandemic preparedness issues.

Rep. Randy Weber (R-TX)
Rep. Rick W. Allen (R-GA)
Rep. Troy Balderson (R-OH)
Rep. Russ Fulcher (R-ID)
Rep. August Pfluger (R-TX)
Rep. Diana Harshbarger (R-TN)
Rep. Mariannette Miller-Meeks (R-IA)
Rep. Kat Cammack (R-CA)
Rep. Jay Obernolt (R-CA)

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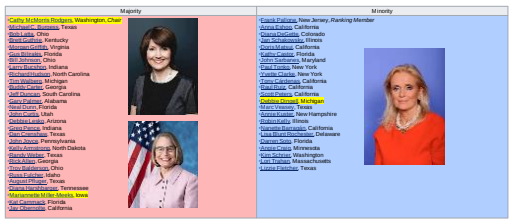
Energy & Commerce Committee



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New Committee Assignments
House Appropriations

The House Appropriations Committee has added ten new Republican members

House Appropriations Chairwoman Kay Granger, R-*TX, said subcommittee chairs would be decided "soon"* but not on Wednesday. A handful of senior appropriators need waivers to continue to lead their preferred subcommittees.

Rep. Stephanie Bice (R-OK)
Rep. Jerry Carl (R-AL)
Rep. Juan Ciscomani (R-AZ)
Rep. Jake Ellzey (R-TX)
Rep. Scott Franklin (R-FL)
Rep. Michael Guest (R-MS)
Rep. Jake LaTurner (R-KS)
Rep. Ryan Zinke (R-MT)

Rep. Carl (R-AL) In 1989, Carl established Stat Medical, a healthcare equipment business. He later worked as a manager at Rotech Medical before establishing a real estate development firm.

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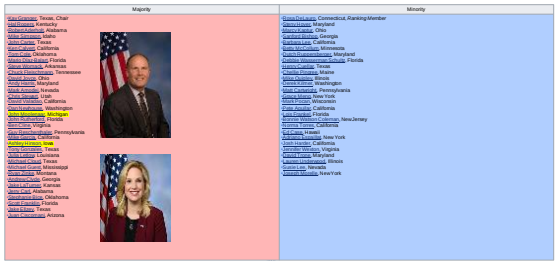
House Appropriations Committee



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New Committee Assignments
Senate Finance

Majority[14]	Minority[15]
•Ron Wyden, Oregon, *Chairman* •Debbie Stabenow, Michigan •Maria Cantwell, Washington •Bob Menendez, New Jersey •Tom Carper, Delaware •Ben Cardin, Maryland •Sherrod Brown, Ohio •Michael Bennet, Colorado •Bob Casey, Pennsylvania •Mark Warner, Virginia •Sheldon Whitehouse, Rhode Island •Maggie Hassan, New Hampshire •Catherine Cortez Masto, Nevada •Elizabeth Warren, Massachusetts	•Mike Crapo, Idaho, *Ranking Member* •Chuck Grassley, Iowa •John Cornyn, Texas •John Thune, South Dakota •Tim Scott, South Carolina •Bill Cassidy, Louisiana •James Lankford, Oklahoma •Steve Daines, Montana •Todd Young, Indiana •John Barrasso, Wyoming •Ron Johnson, Wisconsin •Thom Tillis, North Carolina •Marsha Blackburn, Tennessee

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New Committee Assignments
Senate HELP Committee
118th Congress

Majority[4]	Minority[5]
•Bernie Sanders, Vermont[21] *Chairman* •Patty Murray, Washington •Bob Casey Jr., Pennsylvania •Tammy Baldwin, Wisconsin •Chris Murphy, Connecticut •Tim Kaine, Virginia •Maggie Hassan, New Hampshire •Tina Smith, Minnesota •Ben Ray Luján, New Mexico •John Hickenlooper, Colorado •Ed Markey, Massachusetts	•Bill Cassidy, Louisiana, *Ranking Member* •Rand Paul, Kentucky •Susan Collins, Maine •Lisa Murkowski, Alaska •Mike Braun, Indiana •Roger Marshall, Kansas •Mitt Romney, Utah •Tommy Tuberville, Alabama •Markwayne Mullin, Oklahoma •Ted Budd, North Carolina

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Nationally, the number of DME brick-and-mortars have dwindled in the past decade, 41% of which have left the business.

State	Nov. 2012	Jul. 2013	Jul. 2017	Jan. 2018	Apr. 2018	Jul. 2018	Oct. 2018	Jan. 2019	Jan. 2020	2010-2020 Reduction	2010-2020 Reduction%
NC	508	455	395	367	368	353	349	334	298	-210	-41%
VA	286	271	210	191	191	185	191	181	164	-122	-43%
WV	148	137	132	104	106	104	105	96	75	-73	-49%

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Forecast for 2023:
What needs to happen this year

1) CARES Act- Extension of Non-Rural rates (75/25 Blend) beyond 31 Dec 2023

2) Passage of NEW HR6641 –DMEPOS Relief Act of 2022 (need to find Champion for introduction)

3) *Sequestration 2% and potential for additional "Pay Go" cuts of an additional 4% in 2025*

4) Push for CMS Announcement on a CBP 2024/25?

5) CRT

6) Audit relief

7) MCO's & State Issues

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The ASK of the HME Industry

Reimbursement Relief


Rep. Markwayne Mullin (R-OK)


Rep. Paul Tonko (D-NY)

HR 6641- DMEPOS Relief Act of 2022

- Reps Markwayne Mullin (R—OK) and Paul Tonko (D—NY) drafted legislation to provide a 90/10 blended rate relief to the 13 DME product categories excluded from Competitive Bidding Round 2021, providing relief from 1/1/22-12/31/23.
- Old reimbursement from the flawed Competitive Bidding Program is used to set DME rates and fails to account for the true costs of providing DME, supplies, and services.
- Supply chain disruptions and pandemic challenges affecting staffing, surcharges, added expenses, and more have exacerbated the reimbursement strain suppliers experience.

Extension of the CARES Act

- Extend the blended rate that was extended for 12 months after the end of the COVID-19 Public Health Emergency (PHE) or the next Competitive Bid Program (CBP) Implementation.

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The ASK of the HME Industry

Sequestration - Medicare FFS Claims: 2% Payment Adjustment

- No payment adjustment through March 31, 2022
- 1% payment adjustment April 1 – June 30, 2022
- 2% payment adjustment July 1, 2022

In the midst of the pandemic last year, Congress put the 2% sequestration cut on hold for 2021 to temporarily boost payment to providers as part of their pandemic relief package known as the CARES Act. In 2022, this payment boost will be phased out and sequestration will return, but not until April. At that point, a 1% sequestration will be imposed until June 30, 2022, with the required 2% sequestration returning in July and remaining until the sequestration system expires in 2031. The 2% sequestration was mandated as part of the 2011 Budget Control Act and has been a regular feature of Medicare budgets since 2013.

A plan for averting "PAYGO" cuts.
On top of the 2% sequestration and 3.75% cut, Medicare was also facing a 4% reduction to comply with federally mandated "pay-as-you-go" deficit control budget rules requiring that increases in the federal deficit be offset by increased revenue or cuts to spending. The legislation approved delays implementation of the PAYGO cut until 2023.

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Issues driving legislative efforts

- Poor reimbursement
- Supply chain crisis
- Staffing concerns
- Staff wages
- Fuel prices
- Audits
- State Medicaid/Managed Care Organization concerns
- Medicare Advantage plans

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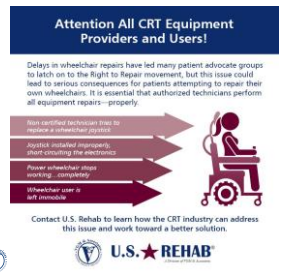
CRT Legislation

Right to Repair

- The legislation originally stemmed from other industries where if passed, consumers would have the right to purchase parts from manufacturers directly in order to repair their own products.
- Hospitals also advocated for this legislation so they could repair their own medical equipment and not need a medical equipment supplier to repair their equipment.



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CMS Announces Comment Period for CRT

Seat Elevation Systems as an Accessory to Power Wheelchairs (Group 3)

CMS announced the opening of a comment period relating to the request for Medicare coverage of power seat elevation systems used with complex power wheelchairs. This is a federally required time period that allows the public to submit data, views, and arguments in regard to a current rule. You can read the full announcement from CMS https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=309

CMS determined that power seat elevation systems **are** reasonable and necessary for individuals using Group 3 power wheelchairs that meet the following conditions:

1. The individual performs weight-bearing transfers to/from the power wheelchair while in the home, using either their upper extremities during a non-level (uneven) sitting transfer and/or their lower extremities during a sit-to-stand transfer. Transfers may be accomplished with or without caregiver assistance and/or the use of assistive equipment (e.g. sliding board, cane, crutch, walker), and,
2. The individual has undergone a specialty evaluation by a practitioner who has specific training and experience in rehabilitation wheelchair evaluations, such as a physical therapist (PT) or occupational therapist (OT), that assesses the individual's ability to safely use the seat elevation equipment in the home.

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Bipartisan Efforts

Our efforts must be supported by both Democrats and Republicans







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Lobby from a Position of Strength

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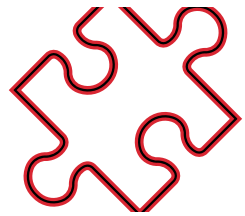
You're part of the solution to some of healthcare's biggest current problems

- Staffing Shortages
- Shifting Consumer Expectations
- Evolving Payment Models
- Hospital-at-Home Programs



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DME services help alleviate staffing issues in hospitals

27

The challenges staffing issues create for hospitals is nuanced, and DME is part of the solution

- Safety concerns
- Throughput issues
- Financial pressures

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Staffing shortages can cause patient safety concerns

- Impacts areas where volume is largely out of facility control
  - Emergency department
  - Inpatient
  - ICU
- Two significant areas of concern related to patient safety
  - Unsafe nurse to patient ratios
  - Staff burnout

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Staffing shortages lead to throughput challenges

ED → ICU → IP → Post-Acute

- Logjams compound staffing and safety issues
- *Inefficiency creates unnecessary "avoidable days"*

30

Hospital "avoidable days" are critical to cost avoidance

- Avoidable days are an unofficial statistic that *you won't find benchmarks on but are critical* to hospital cost avoidance
- Reasons include:
  - Physician discretion
    - Additional therapies
    - Delayed discharge order
  - Family resistance
  - Post-acute coordination

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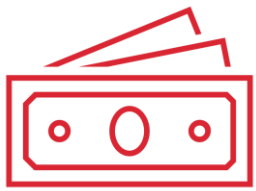
Staffing issues create significant financial burden



- Transfers out cost entire DRG payment
- Surgery, both micro and macro, is critical to the bottom line
- Contract labor is expensive

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Hospital Staffing Based on Patient Volume: How Hospitals Staff Inpatient Units

- Hospitals staff inpatient units based on current census
  - Typical units will allow for 4-5 patients per nurse during daytime
    - More overnight
  - Census is reviewed frequently (such as every four hours)
    - Consideration is given to ED and ICU patients who are likely nearing need of an inpatient bed

While nursing schedules are set weeks/months in advance with best estimates of patient census in mind, near-real-time adjustments are *made by "flexing" staff to meet* current demand and manage costs.

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Hospital staffing based on patient volume: How hospitals staff inpatient units

- Hospitals budget inpatient unit staffing on an Hours-Per-Patient-Day basis (HPPD)
  - For each patient day (midnight census), inpatient units are budgeted for 8-10 nursing hours
  - Not all hours are tied to direct patient care.

Reducing one patient day probably yields ≈8 hours, with variances based on overtime, non-productive hours, and shift overlaps

Example Staffing Matrix:

	Day		Evening		Night	
Census	RNs	Techs	RNs	Techs	RNs	Techs
1	1	0	1	0	1	0
2	1	0	1	0	1	0
3	1	0	1	0	1	0
4	1	0	1	0	1	0
5	1	1	1	0	1	0
6	1	1	1	1	1	0
7	1	1	1	1	1	1
8	1	1	1	1	1	1
9	2	1	1	1	1	1
10	2	1	1	1	1	1
11	2	1	2	1	1	1
12	2	1	2	1	1	1
13	2	2	2	1	2	1
14	2	2	2	1	2	1
15	2	2	2	1	2	1
16	2	2	2	2	2	1
17	3	2	2	2	2	1
18	3	2	2	2	2	1
19	3	2	2	2	2	2
20	3	2	2	2	2	2

34

How much does each hospital inpatient day cost the facility?

Typical Environment:

1 Patient Day ✖ 8 HPPD = 8 Clinical Hours ✖ $30 Estimated Average Hourly Wage = $240 Wages Saved to the Hospital

Current Environment*:

1 Patient Day ✖ 8 HPPD = 8 Clinical Hours ✖ $90 Estimated Average Hourly Wage = $720 Wages Saved to the Hospital

*assumes all avoided wages are contracted traveling nurses

Average nurse pay vs. travel nurse pay for all 50 states (beckershospitalreview.com)

35

The same idea is applied at the hourly level

Getting patients out in a timely manner on the day of discharge is imperative to hospital operations

Admissions have patterns and peak admission time is late morning to early afternoon

36

DME message legislators regarding timely discharges

- Save labor to the tune of up to $1000 per day
- Save on hospital supply costs
- Facilitates improved emergency department throughput

37

Patient preference to be home is more than just satisfaction

38

Patient preference is now entrenched in hospital and physician payments

- Patient satisfaction incentives through CMS and some other payers
  - *CMS' Value*-Based Purchasing program is one example
  - Similar programs exist with many other payers
- *Patient satisfaction is a key cog of the "Triple Aim" and driver of value*-based arrangements

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DME message to hospitals regarding timely discharges

Enabling patients to be home is a patient satisfier

Enabling satisfaction improves physician and hospital performance on several payment models

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Payer contracting with health systems and physicians continues to evolve

41

What's it mean to say payers and providers "share risk"?

- Individual provider or provider entity carries some level of financial risk based on the outcomes and cost of care
  - Value-based purchasing
  - Bundled payments
  - ACOs
  - Population-based payment models
    - Generally, occur when payer and provider group are same entity

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Adoption of payments tied to value continues to grow

- Countless payment models that include at least some level of financial risk to the provider have popped up over the past 10-15 years.
- Payers in both government and private sector have continued to increase risk and reward to providers.

	Definition	Example
Category 1 (No Risk)	Fee-for-service with no link to value	Physician fee schedule or DMEPOS fee schedule
Category 2	Fee-for-service linked to quality and value	Pay-for-performance, HRRP
Category 3	Alternative payment models built on fee-for-service architecture that hold providers financially accountable for performance	Shared savings (ACO) Episodic bundled payments
Category 4 (Full Risk)	Alternative models using population-based payment with safeguards against limiting necessary care	Global capitated budgets (i.e., integrated delivery systems) Prospective bundled payments for chronic conditions

"The Future of Value-Based Payment: A Road Map to 2030", a white paper by Rachel M. Werner, MD, PhD; Ezekiel J. Emanuel, MD, PhD; Hoangmai H. Pham, MD, MPH; Amol S. Navathe, MD, PhD [The Future of Value-Based Payment: A Road Map to 2030 - Penn LDI (upenn.edu)]

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Adoption of payments tied to value continues to grow

	No Risk	FFS w/ Risk	APMs built on FFS	Full Risk
Medicare	10.2%	48.9%	36.5%	4.4%
Medicare Advantage	39.5%	6.9%	36.4%	17.2%
Medicaid	66.1%	10.6%	17.4%	5.9%
Commercial	55.7%	14.2%	27.6%	2.5%
Overall	39.1%	25.1%	30.7%	5.1%

**Distribution as of 2018*

"The Future of Value-Based Payment: A Road Map to 2030", a white paper by Rachel M. Werner, MD, PhD; Ezekiel J. Emanuel, MD, PhD; Hoangmai H. Pham, MD, MPH; Amol S. Navathe, MD, PhD [The Future of Value-Based Payment: A Road Map to 2030 - Penn LDI (upenn.edu)]

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DMEs' common misconceptions about risk-based contracts

DMEs are not *being "locked out" of ACO* contracts

- *They haven't demonstrated* discernable value from their competition

Risk-based contracts *aren't in my* area

- In 2020, the Change Healthcare Pulse Survey suggested that only *14% of provider entities don't* have a consumer-centric strategy in progress

45

This is and will be an ongoing are of influence for DMEs

- Risk-based contracting is **real**
- Risk-based contracting **exists** in most geographic areas
- DMEs do influence success
- Most ACOs/collaborations are immature

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Hospital at Home is rapidly growing

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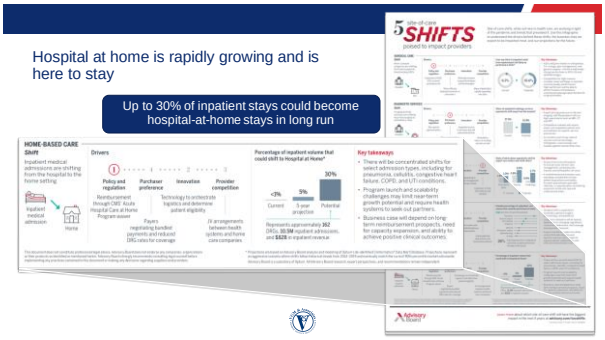
Hospital at home is rapidly growing and is here to stay

Up to 30% of inpatient stays could become hospital-at-home stays in long run



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Hospital at home aims to care for some traditional inpatients in their home

Commonly, patients triaged in the emergency department and then determination is made that inpatient-level care can successfully be delivered in the patient home

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Patients are cared for in the home through a systemic approach

Hospitalist or specialist telemedicine (video) visits

In-home visits from nurse

Telemonitoring devices

Home medical equipment

50

Hospital at home brings great **optimism** *but doesn't come* without barriers

- Payers have obvious incentive
- Hospitals also have incentive
- Aligns with patient preference
- Early evidence of significant outcomes improvements

Source: American Hospital Association Issue Brief: Creating Value by Bringing Hospital Care Home issue-brief-creating-value-by-bringing-hospital-care-home_0.pdf (aha.org)

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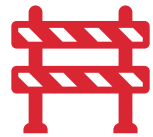
Hospital at home brings great optimism but doesn't come without **barriers**

Most payers don't currently cover hospital-level care in the home

Implementation isn't easy

Demand for hospital-at-home will not rise exponentially until proof-of-concept overrides skepticism



Source: American Hospital Association Issue Brief: Creating Value by Bringing Hospital Care Home (issue-brief-creating-value-by-bringing-hospital-care-home_0.pdf (aha.org))

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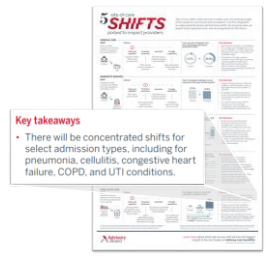
DME are imperative to the success of hospital-to-home programs

- Hospital at home requires equipment in the home that otherwise would be used in the hospital
  - Home oxygen, hospital beds, mobility devices, etc.
  - One would expect DME arrangements to be like current hospice environment
- Focus of hospital at home is largely on chronically ill
  - Traditionally long-term DME patients
- Emphasis is reducing readmissions, SNF stays, ED visits, etc., opening door for DMEs
  - Favors data-driven DMEs who can demonstrate reduced hospital utilization and improved outcomes



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Without DME services, much of what CMS, other payers, and health systems are trying *to achieve isn't possible…*

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DMEs services enable some of CMS' and the rest of healthcare's current goals

- Timeliness of delivery
  - Saves on nursing labor
  - Reduces ED volume
  - Enables hospital-at-home programs
  - Improves patient satisfaction
- Keeping patients in the home
  - Improves patient satisfaction scores which are key drivers *in CMS' and other payer programs*
  - Enables new cost-savings initiatives such as hospital-at-home programs
- Reducing admissions, readmissions, and ED visits
  - Improves risk-based insurance contracting performance, resulting in dollars saved to CMS and other payers

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Lobbying from a position of strength

This does not intend to imply *that any of DME's traditional* talking points are outdated or invalid

Intention is to speak to how DME value directly aligns *with CMS' and other payers'* CURRENT initiatives

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Additional Resources

vgm.com/industrymatterspodcast (Podcast)

vgm.com/news (Blog)

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