August 31, 2022

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., S.W.
Washington, DC 20201

Submitted Electronically to www.regulations.gov

Re: Comments on CMS-4203-NC, "Medicare Program; Request for Information on Medicare Advantage"

1. Introduction.

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members are proud to be part of the continuum of care that assures beneficiaries and other patients receive cost-effective, safe, and reliable home care products and services. Our members supply home oxygen therapy, PAP, ventilator services, complex rehabilitation technology (CRT), urological, ostomy, wound care supplies and many other medically necessary home medical equipment items and services.

AAHomecare and our durable medical equipment prosthetic, orthotic and supplies (DMEPOS) supplier members share Medicare's goal of providing quality and timely equipment and services to Medicare beneficiaries and improving patient outcomes while lowering overall health care expenses. DME suppliers contain health care costs by serving patients in the home (the least expensive site of care). This, in turn, allows patients to be discharged from hospitals, nursing homes, and other health care facilities (the most expensive sites of care) to continue their care in the home setting. DMEPOS is a critical component of the health care continuum, requiring investment and a sound financial footing to preserve continued access to high quality, cost-effective DMEPOS.

The Centers for Medicare and Medicaid Services (CMS) recently issued a formal Request for Information related to various aspects of the Medicare Advantage Program (87 *Fed. Reg*. 46918, August 1, 2022). Twenty years since its inception, the Medicare Advantage (MA) Program now has 28 million participants, representing 46 percent of all Medicare beneficiaries. It is an appropriate time for CMS to closely examine the MA program in its "Vision for Medicare" which aims to place "the person at the center of care and drive a future where people with Medicare receive more equitable, high-quality, and whole-person care that is affordable and sustainable."[1] Over the last 20 years, home care technology has made tremendous strides, enabling an increasing number of patients to receive safe, efficacious, and cost-effective health care at home—the site they prefer to be. Our country's experience with the ongoing COVID-19 public

[1] 87 *Fed. Reg*. 46918.

health emergency has demonstrated that DMEPOS suppliers have been able to take care of many patients at home, thereby alleviating hospital overcrowding.

AAHomecare is pleased to submit comments to the Request for Information. Given our membership perspectives, our comments will focus on issues impacting DMEPOS suppliers. Overall, our comments focus on (i) the pressing need for CMS to exercise significantly more oversight of MA Plans (MAPs), particularly with respect to MAPs compliance with access to care requirements and (ii) the need for a CMS resource with whom DMEPOS suppliers can communicate regarding concerns about MAPs compliance with access to care and other requirements.

2. Need for Improved Oversight of MAPs

a. It is the observation of many DMEPOS suppliers that CMS exercises very little oversight of MAPs, thereby allowing MAPs to make decisions that negatively impact beneficiaries and suppliers. Accordingly, it is important that CMS ensure that DMEPOS suppliers serving MA beneficiaries have access to a grievance and appeals process that includes the opportunity to escalate concerns to CMS. Currently, the MA appeals process does not allow for Medicare appeal rights for some DMEPOS suppliers. To appeal a claims payment decision, a DMEPOS supplier needs written authorization from the patient. Too often, this is impractical and not a requirement for Medicare fee-for-service (FFS).

b. CMS should provide clear guidance to MAPs that they must have coverage and documentation requirements that are no more restrictive than those of Medicare fee-for-service (FFS). MAPs need to consistently apply these coverage and documentation policies. MAPs should be required to follow all waivers and flexibilities issued during PHE and natural disasters issued by CMS.

c. CMS should require MAPs to publish the policies and procedures that DME suppliers are required to follow and should be no more restrictive than Medicare clinical/medical, operational, billing, Advance Beneficiary Notice (ABN), and payment policies. For example, MAPs should be required to publish their policies and procedures regarding prior approval, claims filing, medical policies, documentation requirements, rental caps, billing and pricing modifiers; i.e. KU modifier, and coverage requirements to ensure they are not more stringent than Medicare FFS This includes the 1st month purchase option requirement allowing Complex rehabilitative power wheelchairs (HCPCS codes K0835-K0843 and K0848-K0864) and options/ accessories furnished for use with a complex rehabilitative power wheelchair can be either rented or purchased. This includes use standard remittance reason and remark coding. This will allow for appropriate denial reasons for payment by secondary commercial and Medicaid plans.

d. By law, MAPs are required to establish payment rates that ensure beneficiary access to care. MAPs should be required to demonstrate to CMS that they have completed "access to care" analyses for access to DMEPOS items and services, particularly where there are a limited number of DMEPOS suppliers in a particular geographic area. Importantly, these analyses should be conducted by product category (e.g., respiratory, mobility) because many DMEPOS suppliers do not provide all items of DMEPOS. In addition, MAPs should be required to publicize specific details by product category, how they determine that a provider network is adequate to ensure beneficiary access to care. In addition, MAPs must periodically reevaluate network adequacy due to changes in the product categories that suppliers offer. Access to care analyses should also include ensuring that where a single HCPCS code encompasses a wide diversity in product quality and efficacy that MAP payment rates are sufficient to ensure access to all medically necessary products covered under such code.

e. CMS should designate a central contact/ombudsman with the authority and responsibility to oversee MAPs' compliance with access to care and other requirements. This CMS contact should ensure that adequate recourse is available to DMEPOS suppliers when a MAPs may be out of compliance with (i) its contract with the supplier and/or (ii) its contract with CMS. MAPs should not be allowed to terminate contracts with DMEPOS suppliers when the suppliers seek such recourse.

f. DMEPOS suppliers are concerned about aggressive marketing tactics that many MAPs employ to "lure" beneficiaries to enroll with their plan. CMS should oversee MAPs marketing programs to ensure they are not misleading or false. In addition, it is the experience of our members that many beneficiaries do not fully comprehend their decision to enroll in a MAP; many believe they still have access to their FFS benefits. MAPs should be required to clearly communicate to beneficiaries (i) the fact that they do not have access to FFS benefits and (ii) the benefits that the beneficiaries do and do not have. CMS should refer reports of alleged MAP miscommunications to the appropriate state and/or federal authorities (e.g., state insurance commissioners and the FTC).

g. CMS should require the MAPs to develop and publish DMEPOS supplier-specific (i) dashboards and (ii) reported data metrics. For example, MAPS should be required to publish statistics related to prior authorization (percent approved/denied); number of days between the dates that claims are submitted and paid; appeal statistics; denial rates; and reasons claims are denied. We request that CMS work with AAHomecare in development of these dashboard metrics.

3. Access to Care Issues

a. CMS should require MAPs to establish clear network adequacy criteria by DMEPOS product category and geographic area to ensure there is real patient choice. For example, some DMEPOS suppliers only provide respiratory items and services while others only provide CRT items and services. There should be multiple DMEPOS suppliers providing the same product category in a geographic area. CMS and/or the MAPs should establish metrics to determine when network adequacy has been met for each product category in the DMEPOS space. CMS currently has established time and distance requirements for many other provider types (e.g., hospitals, skilled nursing facilities, physicians and home health agencies). AAHomecare would be happy to work with CMS to develop metrics that would ensure access to care. These metrics must exist for DMEPOS suppliers.

b. CMS should ensure there is a clear channel within CMS for DMEPOS suppliers to escalate concerns when access issues are identified. This results in (i) access issues for beneficiaries due to a lack of competition, (ii) lack of access standards by DMEPOS product category, and (iii) a lack of patient choice for beneficiaries.

c. CMS should ensure that MAPs establish and maintain a "same and similar" portal for DMEPOS suppliers to verify if an MA enrollee is eligible for a specific DMEPOS items(s). This is consistent with traditional Medicare practices and would enable suppliers to ensure a beneficiary has not previously received a similar DMEPOS items(s) recently that would not allow for coverage of a newly ordered item.

d. Our members have grave concerns about certain vertical integration arrangements that are becoming increasingly common in the market. For example, when a payor has common ownership in a DMEPOS supplier, it creates a conflict of interest where the health plan benefits financially with larger market share and higher healthcare cost and could create access to care issues. An example is the recent Humana acquisition of One Homecare Solutions (onehome). Humana is transitioning its members to onehome for authorization, coordination of care, and providing services/equipment. This type of vertical integration (i) restricts access to care, (ii) restricts patient choice, and (iii) results in other DMEPOS suppliers being frozen out of servicing the MAPs' enrollees.

4. Prior Authorization (PA).

a. MAPs should only have PA requirements for DMEPOS items and services when the Medicare FFS program requires PA.

b. MAPs should eliminate PA processes for complex rehab technology service repair claims because these PA processes result in unreasonable delays when the consumer has a need to obtain repair services.

c. When a MAP utilizes PAs, the MAP should have electronic and "real time" processes to ensure timely access.

d. CMS should require MAPs to have an electronic "real time" PA system for DMEPOS items. The PA system should meet the following criteria:

1) PA decisions should be completed and communicated to the DMEPOS supplier, the ordering physician, and the beneficiary within 24 hours or sooner.

2) A PA request for equipment needed on an emergency basis, as determined by the ordering physician, should be "fast tracked" and decided within two or fewer hours.

3) Communication between DMEPOS supplies and MAPs should be electronic from end-to-end, easily accessible by suppliers and free of charge.

4) An affirmative PA for a DMEPOS item should be conclusive with respect to the medical necessity and payment of that item. (Although, claims could be audited subsequently for technical issues such as proof of delivery and suspected fraud, waste, and abuse.)

5) An affirmative PA for a DMEPOS item should be conclusive with respect to the medical necessity for all of the options, supplies, and accessories (submitted at the same time as the underlying item) that will be used with the item. (Although, claims could be audited subsequently for technical issues such as proof of delivery and suspected fraud, waste, and abuse.)

6) An affirmative PA for a DMEPOS item should be conclusive with respect to the medical necessity for (i) resupply items (e.g., for any product category that has an ongoing resupply of medical supplies) and (ii) repairs to the DMEPOS item. (Although, claims could be audited subsequently for technical issues such as proof of delivery and suspected fraud, waste, and abuse).

7) Because a PA is specific to the beneficiary, if the beneficiary moves or changes suppliers, he/she should not need a new PA for the item. (The PA should follow the beneficiary.)

8) The PA length should be consistent with the length of need ordered by the physician. A length of need of 99 should be considered a lifetime need.

5. Drive Innovation; Value Based Care Contracting for DME.

At present, DMEPOS suppliers do not play a significant role in ACOs and value-based arrangements. As discussed above, the DMEPOS industry plays a vital role in reducing hospitalizations. Because DMEPOS suppliers have the ability to drive quality outcomes, CMS should take steps to facilitate the inclusion of suppliers in ACOs and value-based programs.

Thank you for the opportunity to comment. If you have any questions, please contact me at tomr@aahomecare.org.

Sincerely,

Tom Ryan
President and CEO
American Association for Homecare