



*Via Electronic Submission to: [dualeligibles@cassidy.senate.gov](mailto:dualeligibles@cassidy.senate.gov)*

January 13, 2023

The Honorable Bill Cassidy, M.D.  
United States Senate

The Honorable Thomas R. Carper  
United States Senate

The Honorable Tim Scott  
United States Senate

The Honorable Mark R. Warner  
United States Senate

The Honorable John Comyn  
United States Senate

The Honorable Robert Menendez  
United States Senate

**Re: Bipartisan Effort to Improve Care for Patients Jointly Enrolled in Medicare and Medicaid  
(released on November 23, 2022)**

Dear Senators,

The American Association for Homecare (AAHomecare) is pleased to have the opportunity to submit comments on the above-captioned Request for Information. AAHomecare is the national organization for the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) industry, representing suppliers, manufacturers, and other stakeholders in the homecare community. Members provide medical equipment and supplies for patients outside of the hospital setting to continue to improve the management of patients with chronic conditions. Due to our unique position, we have a vested interest in improving policies and processes for the DMEPOS benefit under Medicare and Medicaid.

As Congress reviews ways to improve patient care, we would like to take this opportunity to strongly encourage CMS to endorse e-prescribing to the extent of making it mandatory and allow e-prescribing applications to incorporate the clinical data elements (CDEs) to meet the documentation requirements. The draft CDE templates developed by CMS need to be updated with current documentation and coverage requirements. AAHomecare recommends that CMS collaborate with industry stakeholders in updating draft CDEs and developing additional CDEs for other product categories. Finalized CDEs should contain all

the data elements that are required to qualify a patient for specific DMEPOS. All documentation requirements, such as face-to-face physician evaluations and laboratory results should be eliminated.

To help referring prescribers meet all the Medicare documentation requirements, CMS should move towards requiring all electronic health record (EHR) systems to meet all of CMS' documentation requirements for DMEPOS. In addition, documentation requirements specific to DMEPOS should be required to ensure hospitals, clinics, and physician practices are incorporating these requirements into their daily practices. If properly implemented, EHRs can improve compliance, reduce burden, and enhance communication between all parties. An effective EHR implementation can have a significant effect on reducing administrative burden and improving healthcare delivery.

Below are several suggestions that Congress should consider that will reduce burden for DMEPOS suppliers, health care providers, and ensure care for dually eligible beneficiaries. In this letter, we provide a summary of each issue, the related statute/regulation (as appropriate), and proposed solutions.

## **1. Inconsistencies with HCPCS Codes Amongst Payers**

**There are inconsistencies with HCPCS codes amongst payers. All payer types should recognize all codes. Payers should be required to deny non-covered or ineligible services with accurate denial codes.**

### **Summary:**

There are Healthcare Common Procedure Coding System (HCPCS) code inconsistencies between Medicare, Medicaid, and other third-party payers (S and T HCPCS codes as an example). All payers should recognize all codes and if not covered, deny with correct denial codes from Medicare FFS, Medicare Advantage, Medicaid FFS, Medicaid managed care, and other third-party payers. For example, incontinence products with T HCPCS codes are not covered by Medicare and the HCPCS codes are not recognized, but they are covered by Medicaid. Suppliers must bill an A code that is recognized by Medicare which they must then manually cross-walk to a T code to bill Medicaid. If a supplier attempts to bill Medicare with a T HCPCS code, the claim will reject on the front end and never be processed by Medicare. In addition, Medicare must deny with an appropriate code for the Medicaid programs to make payment; this means a patient responsibility (PR) denial as opposed to a contractual obligation (CO) denial. When a Medicaid program sees a CO denial, they assume there is no patient liability and will not pay for the covered service.

There are also HCPCS code inconsistencies during the transition period when Medicare establishes a new code. Majority of the time, when Medicare publishes a new HCPCS code, other payers take months to adopt the new codes and add it to their systems. This delay in implementation results in access issues for beneficiaries and payment issues for suppliers. In early November, Medicare announced new HCPCS codes for existing temporary continuous glucose monitor codes K0553 and K0554 that went into effect on January 1, 2023. However, there has been no announcement from Medicaid on implementing the

new codes. We believe all payers should acknowledge all HCPCS codes to allow other secondary payers to be able to process covered services for patients.

**Related Statute/Regulation:**

- Health Insurance Portability and Accountability Act (HIPAA, Pub. L. 104-191)

**Proposed Solution:**

Ensure all payers recognize all HCPCS codes so that coverage and denial codes can be consistent across the board.

**2. Medicaid Excessive Documentation Requirements**

**State Medicaid programs should not require any additional documentation when Medicare is primary.**

**Summary:**

State Medicaid programs should not require any additional documentation beyond what Medicare has required for dual-eligible beneficiaries. Some state Medicaid programs require additional documentation beyond what Medicare requires when Medicare is the primary payer. Medicaid programs requiring additional documentation when they are the secondary payer puts beneficiary access to timely service at risk. The Medicaid program should cover the secondary portion without requiring additional documentation or any specific forms.

**Proposed Solution:**

Encourage state Medicaid programs to be less restrictive in their documentation guidelines when they are the secondary payer to Medicare.

**3. Medicaid to Medicare Transition**

**When Medicaid beneficiaries become eligible for Medicare, they should be grandfathered in based on the state Medicaid coverage criteria.**

**Summary:**

When a patient formerly covered by Medicaid becomes Medicare primary, services covered under Medicaid should be grandfathered in as meeting coverage criteria under Medicare. The requirement

for patients to be re-qualified for equipment or medical supplies after already qualifying under a state's Medicaid program is duplicative. Suppliers are forced to restart the costly process of re-qualification even though the patient's equipment and supplies were already proven medically necessary by Medicaid. This process is not only burdensome to suppliers but may create access issues for beneficiaries transitioning from Medicaid primary to Medicare primary.

**Proposed Solution:**

Allow Medicaid-covered items and services to be grandfathered under Medicare when the patient becomes Medicare eligible.

**4. Medicaid Secondary Claims Processing**

**Medicaid as a secondary payer should accept and process all secondary claims for dual eligible beneficiaries in the same manner as Medicare.**

**Summary:**

Several state Medicaid programs process rental claims as a daily rental with spanned dates, whereas Medicare processes rental claims monthly without a date span. When Medicare claims are automatically crossed over to Medicaid, there are issues with how a state Medicaid program processes the secondary claim. This requires suppliers to manually manipulate secondary claims to accommodate the state claims processing requirements. This is a labor-intensive process that is not necessary if Medicare has already approved the primary payment. By requiring state Medicaid programs to process secondary claims for dually eligible beneficiaries as they are received from Medicare, CMS will be reducing supplier burden and ensuring dual eligible patients have the same access to care across all states.

**Related Statute/Regulation/CMS Policy:**

- Medicare Secondary Payor (MSP) Manual (Pub. 100-05)

**Proposed Solution:**

CMS should encourage state Medicaid programs to accept and process all secondary claims for dual eligible beneficiaries as Medicare has.

**5. Medicaid Not Covering Medicare Copay**

**Several Medicaid programs will not pay the full Medicare copay when the Medicaid rate is below the Medicare reimbursement rate for the HCPCS.**

**Summary:**

Medicaid programs are structured very differently from state to state. Many Medicaid programs discount their payment rates by a certain percentage of the Medicare rate. For example, a state Medicaid program may statutorily pay 80% of the Medicare payment rate for items and services. In addition, other states waive the 20% beneficiary co-payment because the state statute requires Medicaid to pay no more than 80% of Medicare for DME. Still, other states combine these two provisions (i.e., the 20% reduction of the Medicare payment rate and waiving the 20% beneficiary copayment amount). Because Medicare is the primary insurance, Medicaid programs are responsible for paying the dual eligible beneficiaries' Medicare co-pays. However, there are inconsistencies across the country regarding how this responsibility is interpreted. When a Medicaid program refuses to pay the co-pay, suppliers that provide services to dual eligibles do not have a recourse to receive payment for their services. Medicaid programs should pay the full Medicare co-pay to ensure suppliers are being properly paid for their services to dually eligible recipients.

**Proposed Solution:**

Require state Medicaid programs to pay the full 20% Medicare co-pay for all situations.

## **6. Medicaid/Medicare Modifiers**

**Medicaid programs must recognize all valid Medicare claim modifiers.**

**Summary:**

Many Medicaid programs do not recognize Medicare required modifiers. This creates a problem for dual eligible patients when Medicare pays as primary and automatically crosses the secondary claim to Medicaid. For example, when a state Medicaid program does not recognize the KX modifier and Medicare processes a claim with the KX modifier, the Medicaid program may not process the secondary portion of the claim without manual manipulation of the claim by the supplier. This requires suppliers to manually manipulate secondary claims to accommodate the state claims processing requirements. This labor-intensive process is burdensome for suppliers and it can be eliminated by requiring state Medicaid programs to process secondary claims for dually eligible beneficiaries as they are received from Medicare. By doing this, CMS will be reducing supplier burden and ensuring dual eligible patients have the same access to care across all states.

**Proposed Solution:**

CMS should encourage state Medicaid programs to recognize all Medicare required modifiers and pay secondary claims appropriately.

## 7. Quantity Limitation

### **Dual eligible patients experience access to care issues when a state Medicaid program allows a higher quantity of an item than Medicare.**

#### **Summary:**

When a Medicaid program has a higher quantity limitation for specific HCPCS codes than Medicare, it is important that Medicare deny the excess quantity of that HCPCS code to allow the Medicaid program to pay for the additional allowed quantities that a dually eligible patient needs. For example, when Medicare only covers one unit of a urological supply per month and Medicaid allows two, if the treating practitioner prescribes two per month, then there needs to be an efficient way for this claim to be processed and paid by Medicare for one unit and then allow Medicaid to receive the secondary claim electronically and pay for the second unit not allowed by Medicare. This would ensure dual eligible patients maintain access to the appropriately prescribed quantities that Medicaid allows, even when Medicaid is the secondary payer.

#### **Proposed Solution:**

Require Medicare contractors to deny the over quantity amounts appropriately and recommend the state Medicaid programs process the claims for the additional quantity for dually eligible patients.

AAHomecare appreciates the opportunity to share the DMEPOS industry's concerns and recommendations to improve coverage for dual eligibles. There are many opportunities to improve policies and procedures and we look forward to continuing the conversation on the issues above. Please feel free to contact me to discuss this in more detail.

Sincerely,



Kimberley S. Brummett, MBA  
Senior Vice President for Regulatory Affairs