JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

August 23, 2016

Submitted electronically: http://www.regulations.gov

Centers for Medicare and Medicaid Services
Attn: CMS-1651-P
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS–1651–P; Medicare Program; End-Stage Renal Disease Prospective Payment System

Justice in Aging appreciates the opportunity to provide a response to the above referenced Notice. Our comments are limited to responding to the Request for Information found in Section IX of the Notice. 81 Fed. Reg. 42802, 42864-65 (June 30, 2016). The RFI asks for information on access issues for dual eligible beneficiaries for durable medical equipment (DME).

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

We are very appreciative that CMS issued a RFI about the important issue of DME access for dual eligibles. We hear from advocates and consumers across the country about beneficiary frustrations in attempting to get medically necessary DME. These frustrations arise from many sources and often the individuals do not know the source of the problem, they only know that they cannot get the DME that they need. The issues are particularly acute for dual eligibles who must navigate the differing criteria and procedures of the Medicare and Medicaid programs. Because DME problems are widespread and persistent, we appreciate that CMS is dedicating resources to tackling the issues and would be pleased to continue to work with the agency to craft solutions.

I. Eliminate procedural barriers to Medicaid prior authorization of DME for dual eligibles

Medicaid's "payer of last resort" policy creates barriers that can leave a beneficiary without access to needed DME. Both Medicare and Medicaid cover DME, though the scope of coverage and the criteria for approval can differ. Because Medicaid is the payer of last resort, state Medicaid programs are prohibited from paying for DME that can be covered by Medicare. A difficulty arises for dual eligibles because Medicare typically does not review a coverage claim until an item has been delivered to the beneficiary. Though Medicaid programs do have prior authorization procedures, some states refuse to start the prior authorization process until there has been a rejection of the claim by Medicare. As a result, in cases where coverage is not clear-cut, DME suppliers, concerned that neither Medicare nor Medicaid will cover the item, refuse delivery, leaving the beneficiary without any way to access needed DME.

The severity of this issue varies among the states. Some states, like Connecticut, have found a way (discussed below) to bypass the problem so that dual eligibles can consistently get claims processed through both programs. In other states, like Texas, beneficiaries just as consistently run into dead ends where they lose access entirely to certain DME because the state refuses to review a claim until the item

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

has been delivered and the claim has been processed through Medicare. In other states, advocates report that they can sometimes break a logjam by finding a Medicaid employee who can perform a manual override to get Medicaid prior authorization, by pleading with the supplier, or by other ad hoc interventions that are time consuming, require the assistance of an advocate and, most importantly, do not address the root problem.

Relying on these piecemeal, ad hoc interventions is not an acceptable, long-lasting solution. In a separate response to the RFI, Justice in Aging and other advocates are urging that CMS assign highest priority to eliminating this problem across all states. We have proposed adoption of the simple and straightforward procedures used by Connecticut and incorporated into the state's statutes. See Conn. Gen. Stat. Sec. 17b-281a. In Connecticut, the state Medicaid program will conduct prior authorization review for any DME, whether or not the beneficiary is a dual eligible and whether or not the DME might be covered by Medicare. We join other advocates in asking that CMS ensure that all states demonstrate to CMS that they have a procedure sufficiently similar to Connecticut's to ensure that access for dual eligibles is equal to those who are Medicaid-only beneficiaries.

While the Connecticut Medicaid program for dual eligibles is fee-for-service, such prior authorization procedures also can and should be instituted in states where Medicaid services for dual eligibles are offered through Medicaid managed care plans. Medicaid managed care plans should be required to institute procedures to provide prior authorization, regardless of whether the beneficiary is a dual eligible.

We hope that CMS can work with states to voluntarily adopt this approach as a best practice. We note however that without this or a procedure that reaches the same result, state Medicaid agencies are denying dual eligible beneficiaries state plan services, in violation of Medicaid law. If needed, CMS should exercise its authority to ensure that all states make mandated DME available to all Medicaid beneficiaries, including those who are dually eligible for both Medicare and Medicaid.

II. Address other DME challenges

While addressing the problem of Medicaid authorizations is the highest priority, it is not the only challenge facing dual eligibles and other beneficiaries attempting to gain access to medically necessary DME. As CMS looks more broadly at issues of access to DME, we ask the agency to also consider a number of other solutions to recurring problems, including:

- **Require Medicaid enrollment for Medicare competitive bidding contractors**. As competitive bidding spreads to more markets and products, we hear of dual eligibles working with competitive bidding contractors to obtain DME and finding that, ultimately, the DME is not covered or not likely to be covered under the Medicare benefit. When the competitive bidding contractor is not also a Medicaid supplier, the beneficiary finds it necessary to start all over, finding a different supplier and beginning anew with required paperwork. If Medicare competitive bidding contractors were required, as part of their bid, to agree to enroll as Medicaid providers in the areas where they are bidding, dual eligibles would not face these complications and delays. Such a requirement would not be overly burdensome and, in light of the very significant market opportunities that competitive bidding contractors enjoy, would be an appropriate condition for successful bidders.

- **Consider excluding complex DME from competitive bid contracting**. A disproportionate number of the issues we hear about relate to complex DME, including but not limited to wheelchairs. Complex DME differs significantly from off the shelf items. Complex DME typically involves specialized adaptation of equipment to the needs of the individual, training of the individual on how to most

effectively use the DME, and frequent adjustment of equipment. Skilled technicians are needed to ensure that the equipment is working well, to address individual needs, and to adjust and repair equipment over time. We have heard from advocates that, since the institution of competitive bidding, the quality and availability of services for complex equipment have declined substantially. Although we recognize that some standards for timeliness and quality are in supplier contracts, it appears that they are not consistently followed. More oversight may help (see below) but we also question whether the almost exclusively price-driven competitive bidding paradigm is really appropriate for complex DME.

- **Establish vigorous oversight of plans and provider performance, timeliness and quality in delivery and repair of DME.** Delays in delivery and repairs of DME have different causes but, in many cases, the blame lies squarely with the supplier and/or the managed care plan, either on the Medicare or the Medicaid side. There is a need for more intense monitoring of supplier and plan performance with respect to DME, including more data collection on such issues as: timeliness of delivery of DME, timeliness of repairs, whether loaner items are provided, complaints by consumers about supply or repairs, etc. Further we ask for closer monitoring of DME denial rates by managed care plans, both on the Medicare and Medicaid side, and the rates at which those denials are overturned on appeal. Both DME suppliers and the managed care companies that contract with the suppliers need to be held accountable for deficiencies through audits, corrective action plans, monetary penalties and, where appropriate, disqualification.

- **Ensure protocols are in place to address urgent situations.** Many problems of DME access arise in urgent circumstances, including cases where a repair or replacement wheelchair is delayed, leaving an individual confined to bed, cases where a hospital discharge is being delayed because needed equipment is not available for the home, and other situations where waiting for resolution can seriously impact a beneficiary's health. The reasons for the problems may vary from slow prior authorizations by Medicare Advantage plans or a state Medicaid program, failure of suppliers to provide prompt service as required by their Medicare and Medicaid contracts, or simple miscommunications. These urgent cases may cut across Medicare and Medicaid lines and the affected beneficiaries may not know where the problem lies.

  In many ways, these cases are similar to those in the Part D context where an individual only has a few days' supply left of a needed prescription drug. CMS has established procedures to address these urgent prescription drug issues and we ask that similar protocols be put in place with respect to urgent DME needs. We appreciate that the Competitive Bidding Ombudsman is one avenue of assistance but ask that CMS work with state counterparts to establish protocols so that emergencies and cases of urgent need can be quickly addressed, regardless of whether the problem is on the Medicare or Medicaid side or whether it is specifically about the performance of a competitive bidding contractor. Beneficiaries, advocates, discharge planners and others seeking urgent assistance need direct routes to get prompt help without being forced to bounce back and forth between agencies and plans.

- Compare Medicare and Medicaid criteria for medical necessity. We have heard reports that while Medicare may cover some DME only when a condition is acute, some Medicaid programs cover continuing use of the same DME to prevent recurrence of acute episodes. As a result, some dual eligibles end up bouncing back and forth between Medicare and Medicaid coverage and beneficiaries without Medicaid face preventable recurrences. We suggest reviewing Medicare DME

criteria that are available for acute conditions only, and updating them as needed to create a more seamless experience for dual eligibles.

- **Address the unique problems of individuals moving from Medicaid-only coverage to dual eligible status.** Advocates report that many beneficiaries who are accustomed to getting all their supplies and services through Medicaid do not understand the changes that they need to make when they become dually eligible. They end up without needed supplies of DME because they have not followed the new rules. Two steps would help address these issues: 1) establish a transition policy for DME similar to the Part D transition policy that would cover suppliers as well as particular items of DME (not only rental items); and 2) create simple consumer fact sheets or a small booklet outlining differences between Medicaid-only coverage and coverage as a dual eligible. The informational materials could cover more than DME and include, for example, brief explanations of the differences in drug coverage and an explanation of balance billing protection. These materials would be very useful to beneficiaries and those assisting them.

Thank you for the opportunity to submit comments. Justice in Aging looks forward to working with CMS to ensure that all beneficiaries, including dual eligibles, have full access to medically necessary DME. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Directing Attorney