Submitted Electronically via www.regulations.gov

January 4, 2023

Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20210

Re: Comments on CMS Proposed Rule: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4205-P; 88 *Fed. Reg*. 78476, November 15, 2023)

Dear Administrator Brooks-LaSure,

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 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 comments focus on the proposals that pertain to Medicare Part B DMEPOS suppliers.

Comments

Enhancing Guardrails for Agent/Broker Compensation – Proposed Changes to 42 C.F.R. §422.2274

CMS is seeking to establish appropriate guardrails for agent and broker compensation to ensure that their payments do not interfere with the agent's or broker's ability to objectively assess and recommend the plan that best fits a beneficiary's health care needs. CMS proposes to generally prohibit contract terms between Medicare Advantage (MA) organizations and agents, brokers, or other third party marketing organizations that may interfere with the agent's or broker's ability to objectively assess and recommend the plan that best fits a beneficiary's health care needs; set a single compensation rate for all plans; revise the scope of items and services included within agent and broker compensation; and eliminate the regulatory framework which currently allows for separate payment to agent and brokers for administrative services. AAHomecare fully supports these CMS proposals. AAHomecare also specifically supports CMS limiting dollar amounts

and incentives to brokers/agent and removing bonus incentives and volume bonuses for brokers/agents. We believe that these guardrails on broker/agent compensation will help provide a more level playing field for all MA plans to compete for beneficiaries to enroll in their plans.

D-SNP PPOs, Limit Out-of-Network Cost Sharing

DME suppliers should be paid an adequate amount to be in network with MA plans so the patient does not have to pay out of pocket for services that are normally reimbursable under Medicare. MA plans 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, MA plans 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, MA plans 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 MA plan payment rates are sufficient to ensure access to all medically necessary products covered under such code.

Related Issues

The following issues are not directly addressed in CMS' proposed rule but are related to issues AAHomecare members frequently experience with MA plans.

Access to Care Issues

While not directly related to one of CMS' specific proposals, we recommend that CMS develop regulatory changes to enhance appropriate access to DMEPOS items and services. Specifically, CMS should require MA plans 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 MA plans 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.

CMS should also 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.

Enrollees Rights/Access to Care

MAs are often denying beneficiaries non-invasive ventilator (NIV) coverage based on a Medicare contractor's RAD (respiratory assist device) LCD (local coverage determination) language, which does not apply to NIV devices. There is not an LCD for NIV. Coverage should be based on the CMS published NIV NCD (national coverage determination). For example, the NIV NCD makes no mention of trying a RAD first and failing to qualify for an NIV device. Furthermore, when NIV is prescribed for lifetime and meets the NCD coverage criteria, MA plans often only approve temporary authorizations and later deny continued

authorization requests with the same medical documentation originally submitted. This creates gaps in coverage for medically necessary life-sustaining devices. The prior authorization 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.

MA plans are also often denying beneficiary access to medically necessary accessories and associated electronics on Group 3 complex power wheelchairs. Coverage for these should be based on the CMS published policies; however, the MA plans are not providing access in line with these policies. Items which the DME MACs will consider covered under the published LCD, associated policy articles, and a "Power Wheelchair Electronics Clarification" article are sometimes denied by MA plans as non-covered due to interpretation issues. The MA plans should be required to follow the CMS policies, not interpret them differently. For example, on a request for power wheelchair electronics E2311 the Medicare policy states that coverage is met when two power seating functions are provided. Some MA plans are denying E2311 in this scenario stating that the wheelchair should be able to operate without the E2311, despite being referred to the existing Medicare policy. This is causing lack of access to the medically appropriate level of power wheelchair or to power mobility altogether. On the off chance that providers are still offering the electronics to beneficiaries, they are having to go through months or even years of appeals and Administrative Law Judge proceedings that lead to the denials being overturned in most cases.

HCPCS Code and Claims Filing Issues

There are Healthcare Common Procedure Coding System (HCPCS) code inconsistencies between Medicare, MA plans and other third-party payers (S and T HCPCS codes as an example). All payers should recognize all HCPCS codes. If a MA plan does not cover a particular HCPCS code, it should issue a denial with correct denial codes that is consistent with traditional Medicare.

There are HCPCS code inconsistencies during the transition period when Medicare establishes a new code. In many instances 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. Medicare Advantage payers should also acknowledge all HCPCS codes and cover the same way as traditional Medicare and to allow other secondary payers to be able to process covered services for patients.

MA plans generally do not issue denial codes that DME suppliers need to obtain payment from a secondary payer. We therefore recommend that CMS require MA plans to issue "patient responsibility" (PR) denials when there is a negative prior authorization determination. While Medicare fee-for-service allows and recognizes the GA modifier (that allows the provider to bill the beneficiary because Medicare does not cover the item/service), MA plans do not issue PR denials or recognize the GA modifier. PR denials are necessary to communicate with secondary payors about the primary insurer's non-coverage decision and allow the secondary insurer to make a coverage and payment decision. Without a PR denial, DME suppliers are unable to collect from a secondary insurance plan and are often forced to write off significant sums of money.

Conclusion

Thank you for the opportunity to provide comments. Please contact me at TomR@AAHomecare.org if you would like further information.

Sincerely,

Tom Ryan
President and CEO
American Association for Homecare