Summary of AAHomecare Comments to CMS on ESRD/DMEPOS Rule – August 21, 2018

AAHomecare sincerely appreciates CMS' proposed ESRD/DMEPOS rule and its significant positive policy proposals that will make meaningful improvements to the competitive bid program (CBP). CMS' proposal to continue the 50-50 blended rate for an additional two years in non-contiguous and rural non-competitive bid areas (non-CBAs) is a significant improvement that will better ensure beneficiary access. We look forward to working collaboratively with the Agency on further DMEPOS policy refinements to ensure that beneficiaries are able to receive medically necessary items and services in their homes. In addition to in-home care being clinically efficacious and cost effective, patients prefer to be in their homes and communities, whether they are dealing with chronic conditions, or recovering from an acute episode.

CBP Improvements: We appreciate and strongly support CMS' suspension of the bid program to provide time to implement meaningful improvements to the bid program. We also support CMS' proposals to improve the CBP which will better ensure beneficiary access to medically necessary DMEPOS items and services. We value the Agency's recognition that certain features of the current bid program processes need to be changed; the Proposed Rule will provide a higher likelihood of the program achieving appropriate beneficiary access and satisfaction, as well as being financially sustainable for taxpayers and for suppliers. We do, however, urge the Agency to make further reforms and refinements that can be made via sub-regulatory guidance, and we will provide the Agency with details in these comments.

Payment in Rural and Non-Contiguous Areas, Other Non-CBAs: AAHomecare is pleased that CMS proposes to extend the 50-50 blended rate in rural and non-contiguous areas during the time period from January 1, 2019 through December 31, 2020. However, we believe the access and durable medical equipment (DME) supplier viability problems CMS has identified are not limited to non-contiguous and rural areas. In the 21st Century Cures law (section 16008), Congress provided payment relief for all non-CBAs, not just those CMS has defined as "rural." Thus, we strongly recommend that CMS provide the same payment relief in the remaining non-CBAs. Without a strong and viable DME supplier infrastructure across the country, beneficiaries will feel the brunt of significant delays and other access issues due to the paucity of available DME firms to provide necessary items and services.

Payment in Former CBAs During Gap Period: AAHomecare has concerns about the Agency's proposal to apply the current CBP single payment amounts (SPAs), plus an inflation index, in the former CBAs, until the next round of bidding can be implemented. Since CMS has recognized

these SPAs are deficient due to the bid program's median price methodology, we are perplexed as to why these inadequate rates should continue, particularly when there no longer remains the increased market share that was the balancing rationale for the lower bid prices in the first place. We therefore recommend that CMS instead pay suppliers a higher rate during the gap period and provide the Agency with recommendations.

Proposed Oxygen Policy Changes: AAHomecare appreciates CMS' concerns about beneficiary access to liquid oxygen services, but we believe there are better ways to accomplish that goal. We urge the Agency to consider a more comprehensive effort to modernize its Medicare oxygen policies, including those for liquid oxygen, to ensure appropriate beneficiary access to medically needed respiratory therapy and would look forward to a collaborative approach that involves all stakeholders.

Gap-Fill Method Replacement: CMS' gap-filling method to establish fees for newly covered items paid on a fee schedule basis should be overhauled. The current gap-fill process is sorely outdated. We recommend that CMS establish a process that includes all stakeholders to develop a reformed gap-fill method that ensures appropriate payment levels and related beneficiary access.

Following is a summary of the key proposals, and AAHomecare's comments.

Competitive Bid Program Proposed Changes/Reforms	
CMS Proposal	**AAHomecare Response**
Suspend the next round of bidding until the new methodology can finalized and implemented.	Support
Maintain bid ceiling at 2015 DMEPOS fee schedule, updated annually	Support
Lead item pricing	Support, as long as the product categories are appropriately defined.
Refine **product categories**	CMS suggests subdividing several product categories, we support, and want to work with CMS to establish product categories. We provided some specific recommendations.
Raise SPA to maximum winning bid	We support, this is consistent with auction economists' recommendations to establish the bid price at the "clearing price." CMS should continue to adjust upward the SPA as it included smaller suppliers, and as suppliers are later added if some of the initial ones no longer participate.

AAHomecare also commented that CMS should implement additional CBP reforms, consistent with auction economists and previous AAHomecare recommendations: need for an Auction Expert and Auction Monitor, increased transparency and stakeholder input, apply uniform payment rules for transitioning DMEPOS competitive bid beneficiaries, establish a prerequisite for bidders to possess a Medicaid Supplier number and meet all state Medicaid requirements prior to bidding in a CBA in that state, and remove CMS' authority to conduct bidding on a "bundled" basis.

Proposed Payment Changes – 2019-2020	
CMS Proposal	**AAHomecare Response**
"Rural" and non-contiguous non-CBAs: CMS proposes to extend 50-50 blend (higher rates) that it provided in May 11, 2018 Interim Final Rule, through December 31, 2020	Support
Remaining non-CBAs: CMS proposes to pay at current rates	We do not believe the access issues are isolated to the very rural areas. Also, typically, the same DME suppliers are serving both rural and remaining non-bid areas. Our data shows that supplier financial viability issues are not isolated to the rural areas, but exist throughout the non-CBAs. A new analysis by Dobson DaVanzo that focuses on these non-rural non-CBAs shows how beneficiaries are being negatively impacted in these areas. Therefore, AAHomecare supports extending same payment relief to these areas as it is proposing for the rural non-bid areas
Former CBAs: Any Medicare DME supplier can provide DME items, and payment would be at the current bid rates plus a CPI-U (single payment amounts, or SPAs)	Since there will no longer be the likelihood of increased demand via limited contractors, and that the current SPAs are based upon a flawed bid methodology, we urge CMS to establish payment in former CBAs at the SPAs plus inflation updates for each year 2013 through 2018 (2013 was the start of the national bid program).
Oxygen and Budget Neutrality; CMS continues to state the law requires it to apply it to payment rates in non-CBAs, even though those rates are derived from CBP SPAs.	AAHomecare urges Congress to pass a law prohibiting CMS from applying the "budget neutrality" provision to payments derived from bid rates as well as SPAs.