



Via Electronic Submission

July 11, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: DEPARTMENT OF HEALTH AND HUMAN SERVICES; Centers for Medicare & Medicaid Services (CMS); Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare [CMS-5507-NC]¹

Dear Administrator Berwick:

The American Association for Homecare (AAHomecare) submits these comments in response to the Centers for Medicare and Medicaid Services' (CMS) request for comments on ways to better align the Medicare and Medicaid programs with respect to services for dual eligible beneficiaries. AAHomecare is the national association representing the interests of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers. AAHomecare members include local, regional, and national manufacturers and suppliers that make or furnish DMEPOS items that Medicare beneficiaries use in their homes. Our members are proud to be part of the continuum of care that assures that Medicare beneficiaries receive cost-effective, safe, and reliable homecare technologies and services.

AAHomecare members serve the "sickest-of-the-sick" Medicare beneficiaries. As the request for comments recognizes, these beneficiaries disproportionately include dual eligible individuals. This population includes the most chronically ill and costly to treat individuals in either the Medicare or Medicaid programs. By virtue of our standing as representatives of DMEPOS suppliers, we are uniquely qualified to comment on the request for comments. As we describe in more detail below, we believe that the needs of Medicare/Medicaid dual eligible patients are best served by removing barriers to access to coverage and payment of home medical equipment, services and supplies. Chronically ill patients prefer to remain at home, not placed in institutions. Moreover, homecare has been demonstrated to be effective for managing the health needs of the chronically ill and in reducing the costs associated with inpatient care of complications resulting from chronic conditions. We discuss these issues in more detail below.

¹ 76 Fed. Reg. 28196 (May 16, 2011).

Homecare Is the Alternative to Costly Institutional Care

Medicare and Medicaid were designed with distinct purposes, which naturally resulted in numerous differences between the two programs in terms of eligibility, payment, and covered benefits. The Medicare program is administered by the Federal Government, and is generally available to elderly individuals or individuals with disabilities. Medicare covers a wide range of health care services and supplies, including acute, post-acute, primary, and specialty care services, as well as prescription drugs. Medicaid is a joint Federal and State program that is administered by States for certain categories of low-income individuals. Although specific benefits may vary by State, in general Medicaid covers acute care, primary and specialty care, behavioral health care, and long-term care supports and services.

Both programs, however, are strongly biased in favor of institutional care. Hospital admissions and readmissions and nursing home care contribute to the high costs of caring for these patients. CMS is aware that reducing these inpatient facility costs to the Medicare and Medicaid programs is essential if it is to meet its goals of providing better quality care to individuals while reducing overall program costs. For example, in the preamble to its proposed rule on accountable care organizations (ACOs), CMS identified reductions in inpatient care and increases in care at home as key expectations for successful ACOs. DMEPOS providers – working in close collaboration with primary care practitioners and specialists – can reduce or delay repeat hospitalizations or more costly skilled nursing care. Reducing barriers to home- or community-based care under Medicare and Medicaid is a fundamental requirement for CMS to meet its goals under the alignment initiative.

The importance of DMEPOS professionals, technologies, and services in managing chronic conditions at home has been recognized recently in a number of studies published in well-regarded peer reviewed studies. In particular, studies have confirmed that treating chronic conditions such as chronic obstructive pulmonary disease (COPD) with technologies designed for home use is an effective alternative to more costly care. For example, Steven H. Landers, M.D. of the Cleveland Clinic describes demographic, clinical, economic, and technological forces that make home-based care “imperative.”² He cites home oxygen therapy as an example of advances in portable medical technology, and cites parenteral nutrition and home infusion therapy as examples of care that is less expensive than and equally as effective as institutional care. He notes that there may be more than 70 million Americans over age 65 by 2030. “Many of these older adults will have limitations on their activities, including difficulty walking and transferring from bed to chair, that make leaving their homes difficult. Older adults are particularly prone to complications of confinement in hospitals, such as delirium, skin conditions, and falls. Treating people at home may be one way to avoid such complications.” The government’s own data suggests that inpatients are also more prone to hospital-acquired infections which result in protracted hospital stays, additional pharmaceutical and care costs, or even stays in skilled nursing facilities (SNFs) if infusion therapy is required.

Other studies have confirmed the importance of access to in-the-home technologies like home oxygen and home infusion in managing chronic disease at lower costs than would be possible in other care settings. An article published in the February 2009 *American Journal of Managed Care* examining long-term oxygen therapy concluded that “continuous oxygen therapy for chronic obstructive pulmonary

² Landers, S. “Why Health Care Is Going Home,” *New England Journal of Medicine*, October 20, 2010.

disease is highly cost-effective.”³ Similarly, a 2004 assessment of clinical literature on long-term oxygen therapy by the U.S. Agency for Healthcare Research and Quality found that oxygen therapy reduces mortality, hospital frequency and length of stay for patients with severe COPD. Specifically, the average number of hospital admissions per patient year decreased from 2.1 to 1.6 and the average number of days hospitalized decreased from 23.7 to 13.4 for patients on long-term oxygen therapy.⁴

Another example of how homecare may be incorporated into a patient’s treatment plan in order to effect program savings is the use of home infusion therapy. Home infusion therapy has been safely and effectively prescribed by primary care and specialty physicians for almost three decades. For example, intravenous antibiotic treatment in the home is highly cost effective compared to providing the same therapy in a hospital or skilled nursing facility. A study described in *Clinical Infectious Diseases* quantified cost savings of a home intravenous antibiotic program in a Medicare managed care plan. The average cost per day of home therapy was \$122, compared to \$798 in the hospital and \$541 in a skilled nursing facility.⁵

Similarly, for patients with chronic diabetes, patient self-monitoring of blood glucose levels has been shown to be highly cost effective in managing expensive complications from insulin-dependent diabetes. An analysis in the *American Journal of Managed Care* documents the extremely large and growing economic burden of diabetes mellitus. However, patient self-monitoring of blood glucose levels has been repeatedly shown to improve glycemic control for insulin-using patients. Clinical guidelines recommend testing at least three times daily for patients with diabetes who use insulin. The report demonstrates cost-effectiveness from self-monitoring.

Recommendations

In order to streamline policies and improve access to homecare for dual eligible individuals, AAHomecare recommends that CMS consider better aligning coverage requirements for DMEPOS. Medicare typically is the primary payer for dual eligible beneficiaries. If items and services are not covered by the Medicare DMEPOS benefit, coverage may be available for the item or service under Medicaid. However, inconsistencies in program requirements create unnecessary hurdles and are a burden to effective delivery of care. For example:

- DMEPOS suppliers might furnish an item to a dual eligible individual that is noncovered by Medicare but which Medicaid covers and pays based on Medicare’s denial. For some items, however, the Medicare claims processing systems will reject, rather than deny, claims for the item. This, in turn, creates hurdles for the supplier billing Medicaid because Medicaid requires a denial by Medicare before it pays the claims.
- Similarly, there may be differences in the type of medical necessity documentation that the two programs require for the same DMEPOS item or service. Many Medicaid programs continue to

³Oba, Y. “Cost-Effectiveness of Long-Term Oxygen Therapy for Chronic Obstructive Pulmonary Disease,” *American Journal of Managed Care*, February 2009.

⁴Lau, J., et al., Long-Term Oxygen Therapy for Severe COPD, June 11, 2004, Tufts-New England Medical Center Evidence Based Practice Center.

⁵Dalovision, J., et al., “Financial Impact of a Home Intravenous Antibiotic Program on a Medicare Managed Care Program,” *Clinical Infectious Diseases*, 2000.

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reject faxed or electronically signed orders or certificates of medical necessity. This forces the supplier to obtain hand written documentation to access Medicaid coverage for the item when the Medicare claim was processed using electronic signatures. Documentation issues also include differences in the frequency of renewing certifications and orders between the two programs. Inasmuch as Medicare is the primary payer in these situations, Medicare documentation rules should be applied in accessing Medicaid coverage.

- There are also differences between the two programs regarding who may prescribe DMEPOS items. Although generally, this is controlled by state law, some states have administrative program rules that may impose additional requirements to state statutes. Inconsistencies between the two programs in who may prescribe DMEPOS items and services impede access to care, especially in rural or medically underserved areas.
- Differences in coding and payment for DMEPOS between the programs also impede adequate access to homecare products and services. Medicaid programs use a variety of different payment methodologies for DMEPOS items. For example, Medicaid programs sometimes unbundle payments for items that are bundled under Medicare or vice versa. Medicaid programs also code products under HCPCS codes that are different from those used by Medicare. There needs to be better alignment between the two programs in what products and services are covered under applicable HCPCS codes and how those products and services are reimbursed.

Conclusion

AAHomecare appreciates the opportunity to submit these comments. We strongly believe that broader access to quality home medical equipment and services is the key to successfully treat and manage individuals with chronic conditions and meet the fiscal challenges faced by Medicare and Medicaid.

Please feel free to contact me at (703) 535-1894 if you would like to discuss these comments in more detail.

Sincerely,



Walter Gorski

Vice President, Government Affairs