



October 10, 2018

A. Nicole Clowers
U.S. Government Accountability Office
441 G St., NW
Washington, DC 20548
clowersa@gao.gov

Dear Ms. Clowers:

As the national association for DMEPOS suppliers, manufacturers, and other industry stakeholders, the American Association for Homecare (AAHomecare) would like to submit our response to the Government Accountability Office (GAO) report, “Medicare Fee-For-Service; Information on the First Year of Nationwide Reduced Payment Rates for Durable Medical Equipment,”¹ examined potential effects of the reduced rates for DME in non-competitive bid areas (non-CBAs) that took effect January 1, 2016. The Centers for Medicare and Medicaid Services (CMS) is required to use information from the DME competitive bidding program to adjust Medicare fee-for-service rates for DME items included in the bid program, in areas that are not part of the bid program, starting January 1, 2016. CMS simply used the bid program rates and applied them to the remaining areas of the country, despite there being no limited number of contractors with an ensuing expected increase in volume.

Following are GAO findings, and AAHomecare’s responses:

1. FFS payment Rate Reductions Were Generally Significant

AAHomecare: We agree.

The competitive bid program has produced unsustainably low rates, due to a flawed bid system. CMS has acknowledged these flaws in two recent rules. In its May 11, 2018 interim final rule (IFR), CMS acknowledged that the extremely low bid rates that were used to set rates in rural areas of the country have produced access issues.² As a result, CMS raised rates in these areas

¹ GAO-18-534, July 2018.

² *Medicare Program; Durable Medical Equipment Fee Schedule Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and on-Contiguous Areas*, 83 Fed. Reg 21912 (May 11, 2018).

from June 1 through December 31, 2018. In its proposed rule issued July 19, 2018, CMS has proposed to continue those increased rates in rural areas through 2019 and 2020. CMS has also proposed to reform the bid program rate calculation methodology that would increase bid rates. Specifically, CMS is proposing to use the “maximum winning bid” to set the bid rates, instead of the current “median bid” methodology. CMS explained that the current method will result in a financially unsustainable program, that will cause access issues.

2. The Number of DME Suppliers in Non-Bid Areas Continued a Trend of Annual Decreases

AAHomecare: We agree.

AAHomecare analysis confirms that there have been a significant number of DME supplier closures in all non-CBAs, those that are rural and non-contiguous, and those that are not.³ CMS has also identified a decrease in the number of DME suppliers and has raised the issue that this could present access problems. In its May 11, 2018 IFR, CMS stated that the number of suppliers serving non-CBAs is steadily abating, and that CMS does not know whether the remaining suppliers “will have the financial ability to continue expanding their businesses to continue to satisfy market demand.”⁴ Based on an analysis of CMS data, AAHomecare has identified a significant number of supplier location closures in all non-CBAs. From 2010 to 2018, 31 percent of locations in rural areas have closed, and 33 percent of non-rural (non-CBA) supplier locations have closed.⁵ The very same beneficiary access and supplier viability issues that CMS has identified in the rural and non-contiguous areas also exist in the remaining non-CBAs. As CMS has acknowledged, a financially viable DME supplier market is necessary because “reduced access to DME may put beneficiaries at risk of poor health outcomes or increase the length of hospital stays.”⁶

3. Available evidence indicates no widespread access issues in the first year of reduced DME payment rates in non-bid areas

AAHomecare: We disagree, and CMS has also raised the issue that access issues may be arising due to the number of DME supplier closures.

In its May 11, 2018 IFR, CMS recognized that the decreasing number of DME suppliers could present real issues for beneficiary access.⁷ In that IFR, CMS expressed its concern that the reduced number of suppliers will have “the financial ability to continue expanding their businesses to continue to satisfy market demand.”⁸ CMS continued, “We recognize that reduced

³ AAHomecare analysis of CMS data obtained via a FOIA request to the Pricing, Data Analysis and Coding (PDAC) contractor; analysis of number of DME suppliers who provide hospital beds, wheelchairs, oxygen, RAD, CPAP, support surfaces, NPWT, ostomy, urological, and enteral nutrition items and services.

⁴ 83 *Fed. Reg.* 21912 at 21918.

⁵ AAHomecare analysis of 2010-2018 Medicare NPI data obtained from CMS via FOIA requests; it includes suppliers providing the following product categories: hospital beds, wheelchairs (complex and standard), oxygen, RAD, CPAP, support surfaces, NPWT, ostomy items, urologicals, and enteral nutrition.

⁶ 83 *Fed. Reg.* at 21918.

⁷ *Id.*

⁸ *Id.*

access to DME may put beneficiaries at risk of poor health outcomes or increase the length of hospital stays.”⁹ As a result of its findings, CMS raised the payment rates in non-rural and non-contiguous areas of the country from June 1 through December 31, 2018 to address its access concerns. In its proposed rule issued July 19, 2018, CMS echoed those concerns and proposed to continue those higher payment rates through 2020.¹⁰ These CMS policy initiatives clearly illustrate the existence of access issues resulting from the reduced payment rates in non-CBAs.

Several recent studies illustrate the DME supplier viability and associated access issues that exist across the country, in both bid areas and non-CBAs. A November 2017 study by Dobson DaVanzo & Associates, “*Access to Home Medical Equipment: Survey of Beneficiary, Case Manager, and Supplier Experiences*,” found that beneficiaries and case managers have reported adverse changes to access and availability to oxygen therapy and DME and supplies since July 1, 2016.¹¹ Beneficiaries self-reported intentionally bypassing the Medicare DME benefit they are entitled to and are instead paying for equipment and supplies out-of-pocket to avoid delays and inaccessible equipment. Those reports were corroborated by case managers’ reports on beneficiary complaints.¹²

A more recent Dobson DaVanzo & Associates report focused on issues in non-rural non-CBAs. This August 15, 2018 study, “*Beneficiary Access to DME at National Level as compared to Beneficiary Access in Non-Rural-Non-Bid Areas*,” found results in this subset area to be similar to the results reported in its November 2017 report.¹³ In these non-rural non-CBAs, Dobson DaVanzo found widespread dissatisfaction by beneficiaries and case managers, indicating market failures: access and availability, increased readmissions, delays of medically necessary equipment and increased out-of-pocket expenses. More specifically, between 41 and 83 percent of beneficiaries reported some level of access issues in obtaining medically necessary DME items in all product categories, 46 percent of beneficiaries reported delays in receiving their items, and 48 percent of beneficiaries reported increased out-of-pocket medical costs for their DME and supplies.¹⁴ Ninety two percent of case managers in non-rural non-CBAs reported delays in hospital discharges or a delay in the HME and/or supplies.¹⁵ Sixty-five percent of case managers reported beneficiary complications, emergency care, or readmissions due to issues with HME.¹⁶

The California Hospital Association (CHA) has identified the fact that California hospitals and post-acute providers have reported significant delays in being able to obtain timely delivery of DME

⁹ *Id.*

¹⁰ *Medicare Program; ESRD PPS, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, ESRD Quality Incentive Program, DMEPOS Competitive Bidding Program and Fee Schedule Amounts, and Technical Amendments to Correct Existing Regulations Related to the CBP for Certain DMEPOS*, 83 Fed. Reg. 34304 (July 19, 2018)

¹¹ Dobson, A., Heath S., et al. 2017, “*Access to Home Medical Equipment: Survey of Beneficiary, Case Manager, and Supplier Experiences*.”

¹² *Id.*

¹³ Dobson, A., Heath S., et al 2018, “*Beneficiary Access to DME at National Level as compared to Beneficiary Access in Non-Rural Non-Bid Areas*.”

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

for patients to ensure safe discharge from the hospital or other post-acute care settings.¹⁷ CHA also found that these access issues are occurring in both CBAs and non-CBAs, and documented these access issues in their comments to CMS submitted in response to CMS' July 19, 2018 proposed rule.¹⁸ CHA noted that California hospitals and post-acute care providers report significant difficulties in obtaining timely delivery of medically necessary DME for Medicare beneficiaries upon hospital discharge, and that since CMS implemented the CBP, this issue has become increasingly acute.¹⁹

The American Thoracic Society (ATS) published a peer reviewed study on October 19, 2017, "Patient Perception of the Adequacy of Supplemental Oxygen Therapy: Results of the American Thoracic Society Nursing Assembly Oxygen Working Group Survey," (ATS Study) which found that 50 percent of all respondents reporting having "problems" accessing oxygen.²⁰ The ATS Study concluded that systemic problems exist within the DME industry concerning oxygen therapy that significantly and negatively affect non-Medicare and Medicare beneficiaries' ability to access necessary and quality items to facilitate their lifestyles.

Members of Congress have heard extensive reports around the country regarding access problems caused by the low payment rates, both in and out of CBAs. As a result, there are currently 156 U.S. Representatives who have co-sponsored H.R. 4229, a bill that would provide payment relief to DME suppliers serving beneficiaries in all non-CBAs, not just those that are in rural and non-contiguous areas. Further, in its FY 2018 Budget Appropriations law, Congress included Conference Report language urging the Administration to implement this IFR, as a measure to address some of the apparent problems resulting from the low payment rates.²¹

In response to CMS' May 11, 2018 IFR,²² the Congressional delegation representing the state of West Virginia sent CMS a letter expressing its serious concerns that the payment relief in the IFR did "not go far enough to ensure continued access for the elderly and disabled who rely on this equipment and those who service it."²³ The Congressional delegation explained how West Virginia has lost 38 percent of its providers in the last two years, and that it has repeatedly expressed its concerns to CMS about the higher costs that providers in West Virginia incur relative to their urban counterparts. Importantly, the delegation explained that CMS' definition of "rural" does not comport with the reality of West Virginia where many areas it considers "rural" CMS does not.

¹⁷ March 2018. Memo from California Hospital Association to California Hospital Association Member Case Management Executives titled: *Action Needed: Reporting of Challenges in Obtaining Timely DME for Discharge*.

¹⁸ September 10, 2018 CHA comments to CMS on CMS-1691-P, Medicare Program ESRD PPS, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, DMEPOS Competitive Bidding Program and Fee Schedule Amounts (83 Fed. Reg 21912, July 19, 2018).

¹⁹ Id.

²⁰ Jacobs SS, Lindell KO, Collins EG, et al. "Patient Perceptions of the Adequacy of Supplemental Oxygen Therapy. Results of the American Thoracic Society Nursing Assembly Oxygen Working Group Survey." *Annals of the American Thoracic Society*, Vol. 15, No. 1, Jan 01, 2018.

²¹ See Conference Report (Division H, page 49) accompanying H.R. 1625, the Consolidated Appropriations Act of 2018 (P.L.115-141).

²² 83 Fed. Reg. 21912.

²³ July 18, 2018 letter to CMS Administrator Seem Verma from Sens. Joe Manchin III, Shelley Moore Capito, and Representatives David McKinley, Alex Mooney, and Evan Jenkins.

All these reports, which come from beneficiaries, caregivers, hospitals and other providers, as well as from federal policy makers, clearly demonstrate the extensive and serious access issues beneficiaries are facing across the country. The problems stem from the dramatic reductions in payment rates and the number of DME suppliers available to provide medically necessary DMEPOS items to beneficiaries.

4. The Percentage of Medicare Enrolled Participating Suppliers and Rates of Assignment for Rate-Adjusted Items Did Not Change Following the Implementation of Adjusted Rates

AAHomecare: We agree but note that these are not good indicators of access issues.

There are a number of hurdles that make it very challenging or prohibitive for suppliers to change their practices and file claims on a non-assigned basis:

- **Prohibition on filing non-assigned claims for dual eligible beneficiaries:** The Social Security Act requires suppliers who serve beneficiaries with both Medicare and Medicaid (“dual eligibles”) to accept assignment.²⁴ These beneficiaries account for about 20 percent of all Medicare beneficiaries.²⁵ CMS also states that dual eligibles “account for a disproportionately large share of expenditures in both the Medicare and Medicaid programs,” amplifying that number well beyond 1 in 5.²⁶
- **Limited opportunities to switch from participating to non-participating supplier:** A supplier is bound to its current status for the full calendar year. To become a non-participating supplier, the supplier must notify the National Supplier Clearinghouse in writing during the supplier agreement enrollment period, generally mid-November to late December. The change does not take effect until January 1 of the following year.
- **Inadequate CMS guidance on filing non-assigned claims:** There is limited CMS guidance on the procedures for filing non-assigned claims, and without greater education, suppliers are unable to determine if they are at risk for audits and recoupment regarding issues like defining “excess” and “customary charges,” filing assigned and non-assigned claims on the same day.
- **Risk of non-payment by beneficiaries for capped rental items:** For capped rental items, the supplier directly collects payment from the beneficiary monthly and must get the beneficiary to sign a Signature Authorization Form each month. This process creates additional workloads for the supplier and can be confusing to beneficiaries.

²⁴ SSA, Section 1848(g)(3)(A)

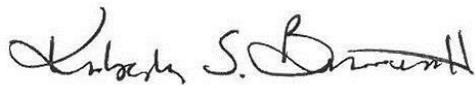
²⁵ Medicare-Medicaid Coordination Office. Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006-2013. December 2014. Retrieved at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment20062013.pdf>

²⁶ Medicare-Medicaid Coordination Office. People Enrolled in Medicare and Medicaid. February 2018. Retrieved at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

- **Specific Supplier Communications must be made to Medicare beneficiaries in advance of changes:** A supplier is required to notify current beneficiaries no less than 30 days prior to changing its assignment practices and/or the products offered on an assigned basis.

AAHomecare appreciates the opportunity to provide feedback on this important study. As stated above, there are many areas within the GAO's findings on access and utilization of DME items that does not reflect what the industry, other stakeholders, and independent studies have reported. We look forward to further discussions on this issue. Please feel free to contact me if I can answer any questions about our comments above.

Sincerely,



Kimberley S. Brummett
Vice President of Regulatory Affairs
American Association for Homecare