



Via Electronic Submission to: <https://www.regulations.gov>

September 11, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1678-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1678-P)

To Whom It May Concern:

The American Association for Homecare (AAHomecare) is pleased to have the opportunity to submit comments on the above captioned proposed rule. AAHomecare is the national organization for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) industry, representing suppliers, manufacturers, and other stakeholders in the homecare community. Members provide medical equipment to patients outside of the hospital setting to continue to improve the management of chronic conditions. Due to our unique position, we have a vested interest in protecting the DMEPOS benefit under the Medicare program.

We are submitting these comments in response to the Request for Information within the proposed rule regarding the Centers for Medicare and Medicaid Services' (CMS') efforts to "increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple and accessible."

AAHomecare strongly supports CMS' efforts to improve health care delivery and health outcomes for patients. We believe there are many burdensome regulations that contribute to the inefficiencies and ineffectiveness of the program. We would like to take this opportunity to

share the issues regarding Healthcare Common Procedure Coding System (HCPCS) and the reforms necessary to improve patient access to medically necessary products.

The current HCPCS code set for DMEPOS is inadequate. There appears to be an institutional unwillingness to expand the HCPCS code set. This has resulted in a myriad of problems including:

- Under-defined codes that contain too broad a range of products with a subjective code verification process.
- Products that receive payment rates that are too low, or too high.
- A disincentive to innovate.
- A lack of new/appropriate codes for innovative technologies and enhancements.
- The inability to use an Advance Beneficiary Notice (ABN) to allow a beneficiary to upgrade products within the same HCPCS code. This prevents beneficiaries from applying their Medicare benefit towards a DMEPOS item that provides them more value.

There are numerous HCPCS codes that do not represent a homogenous group of products but rather include a broad range of items from simple items to high-end complex items (such as HCPCS code E0955, a wheelchair headrest code which includes everything from “foam on a stick” to very complex head support systems and E0978, a positioning belt/safety belt/pelvic strap code which includes everything from very basic seat belts to complex pelvic support systems). The problem with grouping a wide range of technology under one code is that it fails to adequately recognize and reflect unique features, applications, and benefits. Further, since the payment rate is established at the HCPCS code level, it inadequately compensates for more complex/costly items while potentially overcompensating simple/inexpensive items assigned to the same code.

The lack of specifications and unwillingness to routinely enhance coding and code descriptors discourages manufacturers from developing product improvements and new products that could benefit the user clinically and/or functionally. Typically, HCPCS codes include minimum product specifications that a product must meet in order to use the associated code for billing. However, in many cases these specifications are very minimal and only reflect the materials and technology that existed at the point the code was created. Any function and form requirements established by the Pricing, Data Analysis and Coding (PDAC) Contractor that goes beyond the full HCPCS code descriptions are subjective and the Contractor does not publish decisions for stakeholder feedback.

CMS displays a strong aversion to expanding the HCPCS code set, as well as a concern about the impact additional HCPCS codes will have on its competitive bidding program. These concerns must be overcome and a more reasoned policy put in place that allows for more codes, along with more specifications in codes and coding that considers materials, durability, features and/or applications. There are many DME items that do not have a proper code. For example, Medicare has established HCPCS codes for oversized/bariatric hospital beds; but, no codes exist for bariatric sizes of full support surfaces that would be placed on such beds. Recently CMS

published an article reinforcing its unwillingness to recognize bariatric sized support surfaces,¹ even though the design, materials, and costs associated with bariatric sized support surfaces would increase, just as it does for bed frames.

These issues ultimately punish the beneficiaries who would greatly benefit from these enhanced goods and services. Medicare's regulations encourage product offerings based on lowest cost rather than quality, durability, and efficiency. As a result, Medicare beneficiaries maybe less likely to receive advanced materials and technology. The broad grouping of HCPCS codes places premium products at a competitive disadvantage by assigning them to HCPCS codes that are inadequate and under reimbursed, while providing cheap products with a competitive advantage. The burdens associated with administering ABN upgrades for products within the same HCPCS codes further exacerbates this problem because beneficiaries cannot utilize their Medicare benefit towards a medically necessary item and pay extra for the feature or benefit they value. CMS needs to expand HCPCS coding to ensure that each code represents a distinct, homogenous group of products and stop co-mingling disparate items.

Even if CMS were to act to address the problems that exist with the HCPCS coding system for DMEPOS, it cannot address the problems that exist unless the methodology for calculating payment rates (gap filling) is also reworked. The current gap fill method gives each product identified and assigned to a HCPCS code equal weight in the calculations. Each included product goes through the calculations to deflate its price back to 1987. Then the median price is identified amongst all of the included products. This single, median price is then re-inflated to calculate a current-year payment rate for the HCPCS code, and all products assigned to the code. The problems with this methodology include:

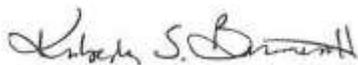
- This methodology fails to recognize market demand and clinical preference in the calculations. For example, in considering the products assigned to a HCPCS code, one item may represent 30% of demand while another might not have any market demand. Yet, each is given an equal weight in identifying the median deflated price. To more fairly identify the median price, each item included should be weighted based on historic market demand.
- The current method of deflating current year pricing to 1987 and then re-inflating to present day is likely to calculate payment rates that are too low. Further, if the current method is extended too far into the future it will return payment rates of "\$0.00." Since the gap fill methodology was adopted, CMS has applied deflation rate for each year back to 1987, but has omitted any inflation rate for years where DME payment rates were frozen (something not anticipated or considered when the method was created in the 1980s). In calculating current year payment rates for items that did not exist in 1987, it is inappropriate to apply a deflation rate for any year, unless an inflation rate for the same year is also applied.
- The gap fill methodology, in combination with under-defined coding, creates a competitive advantage for providing the cheapest products assigned to a code which could reduce beneficiaries' access to the goods and services that they need.

¹ Noridian Healthcare Solutions. Correct Coding- Bariatric Pressure Reducing Support Surfaces. July 27, 2017. Retrieved from: <https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/correct-coding-bariatric-pressure-reducing-support-surfaces>

CMS needs to replace the current gap filling methodology it utilizes to calculate the payment rate for new and updated HCPCS codes. The current methodology is out of date and insufficient. To develop a more robust reimbursement calculation procedure, CMS should collaborate with stakeholders to develop an alternative to this current methodology.

Reforms to the HCPCS coding and gap fill methodology are needed to protect the Medicare DMEPOS benefit. The inefficiencies of HCPCS coding process limits Medicare beneficiaries from receiving the medically necessary equipment that they need and gap fill methodology must be modernized to reflect the true cost of the equipment. AAHomecare appreciates the opportunity to share the DMEPOS industry's concerns and we welcome further conversations on the issues included here.

Sincerely,

A handwritten signature in black ink, appearing to read "Kimberley S. Brummett".

Kimberley S. Brummett, MBA
Vice President for Regulatory Affairs