Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Proposed Rule: Medicare Program — End-Stage Renal Disease Prospective Payment System, Coverage and Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program Bid Surety Bonds, State Licensure and Appeals Process for Breach of Contract Actions, Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program and Fee Schedule Adjustments, Access to Care Issues for Durable Medical Equipment; and the Comprehensive End-Stage Renal Disease Care Model (CMS-1651-P)

August 22, 2016

Dear Acting Administrator Slavitt:

The University of California (UC) Health system, America’s largest academic health system, includes 12 hospitals and 18 health professional schools spread over seven campuses located in Berkeley, Davis, Irvine, Los Angeles, Riverside, San Diego, and San Francisco. UC Health is grateful for this opportunity to share input on proposed policies impacting access to durable medical equipment (DME) for Medicare and Medicaid beneficiaries, including the impact of the Competitive Bidding program (CBP).

**Competitive Bidding Program**

In the proposed rule, CMS advances several requirements for participants in the CBP, including licensure requirements and supplier appeal procedures, and revises the bidding methodology and fee schedule.

UC Health asks CMS to carefully evaluate all proposed changes to the CBP and their potential impact on the customer service suppliers provide to providers. Hospitals within the UC Health system continue to report significant problems in obtaining DME for their patients. CBP implementation has led to a number of unintended consequences that, with proper oversight and program changes, can be avoided.
Shortly after the CBP’s implementation, hospitals throughout California began to report difficulty obtaining medically necessary equipment on a timely basis. In some cases, they reported that designated suppliers had dropped out of the program, thus limiting DME availability in the region. In others, suppliers implemented reduced or inflexible delivery schedules, or required that a family member pick up the item at a storefront location. While we appreciate that a new program will encounter some challenges, we are concerned that many have yet to be fully resolved despite several years of implementation.

Consequently, Medicare beneficiaries continue to encounter delays in obtaining medically necessary DME. Patient discharges are delayed; in many cases, patients are discharged with equipment loaned from the hospital. In some cases, patients and their families have reportedly purchased items at their own expense — even when the items should have been provided and paid for by Medicare. We have also received reports of staff purchasing used walkers to provide to patients who would otherwise have waited to obtain them from suppliers, or stocking a donor closet of used equipment to distribute as needed.

Hospital personnel note that, prior to the CBP’s implementation, case managers and discharge planners were able to select DME suppliers based on their level of customer service, including their demonstrated dependability and consistency in delivering required items within the necessary time frames. They express frustration that they are no longer able to select DME suppliers based on what is in the patient’s best interest, but must use suppliers that, in their view, provide sub-standard customer service and often cannot meet the patient’s needs —ultimately compromising care outcomes.

Recently, UC Health has been party to efforts by the California Hospital Association (CHA), as well as physicians at UC San Francisco (UCSF) and case managers at UC Davis, to facilitate communication with regional and national CMS personnel in an effort to identify problems with the CBP and offer solutions. UC Health’s UCSF and UC Davis medical centers have been parties to CHA’s efforts to work with CMS Region 9 and the CBP Ombudsman to facilitate provider education for hospital case managers. While we acknowledge a process for providers to report formal complaints exists, we do not believe it is meeting the needs of beneficiaries and providers to ensure patients receive timely problem resolution. In addition, the multiple processes outlined by CMS have made it difficult for hospitals to escalate issues and resolve issues in a timely way.

For example, California hospitals took steps to avail themselves of the competitive bidding implementation contractor (CBIC) process. UC Health appreciates the action CMS took late last year in response to issues raised. However, our UC hospitals report no significant change in supplier behavior and customer service or DME availability for patients in certain areas of California. UC Health believes that more must be done to streamline multiple layers of oversight and provide hospitals and beneficiaries with the resources needed for more immediate resolution of DME provision.

Most recently, CMS has directed providers to contact 1-800-Medicare to report problems and obtain assistance. Initial reports from case managers on their experience with 1-800-Medicare reflect confusion about the roles of customer service representatives’ (CSR) hospitals, and a lack of shared expectations regarding problem resolution. Providers contact 1-800-Medicare with the expectation that a CSR can intervene with a supplier and ensure access to DME for the
beneficiary at the time of discharge or shortly thereafter. Unfortunately, hospitals do not report any intervention by the CSRs beyond providing a list of DME providers from the website. UC Health believes Medicare should capture situations in which a hospital case manager has called every listed DME provider and none are able to meet the expectations for timely delivery to the hospital or beneficiary home to ensure a safe discharge. It is UC Health’s understanding from CMS that it is within the purview of the CSR to take appropriate steps during the call to intervene and help to secure the equipment. If the CSR cannot resolve the issue, it should be captured as a complaint and forwarded to the ombudsman. Notably, hospitals should receive a written confirmation or email confirming the date and time that the complaint has been registered, so that it can be expedited by the Ombudsman’s office.

Without an intervention or a necessary escalation of the issue, as well as confirmation via email or a tracking number, the hospital discharge remains delayed. Adding insult to injury, case managers report lengthy wait times in accessing CSRs during business hours. UC Health asks CMS to revisit CSR education and strongly consider a touch pad option for hospital case managers so to ensure direct access to a specially trained CSR who can work with providers and suppliers on timely resolution of these issues.

Due to multiple processes provided to hospitals for reporting issues and concerns (CBIC, 1-800-Medicare and the ombudsman), each with their own method for capturing the information and different criteria for action, the effectiveness of any one process has led to frustration by hospitals and subsequent reporting fatigue. This directly corresponds with what we believe to be an understatement of the scope and frequency of DME access problems and their impact.

As previously mentioned, UC Health, through efforts CHA has undertaken, in partnership with CMS and the Ombudsman, is educating providers about these various processes — but we believe additional steps can be taken to improve DME access. UC Health urges CMS to work with providers to develop and tailor a process specific to timely resolution of the provision of DME for hospitals and other post-acute care providers. We believe that one conduit for the issue’s identification and resolution, with appropriate steps for escalation, is the only way CMS will truly be able to capture real time information that can be evaluated and acted upon. An effective and well-utilized reporting process will resolve problems on a timely basis, and will collect information and data to inform future program changes.

While we recognize that this process may not be achievable on a national scale at first, we urge CMS to consider pilot programs in California to test the scalability of an approach that could refined as needed.

UC Health appreciates CMS’ efforts in providing recent oversight including secret shopping, and we urge CMS to take additional steps to investigate and evaluate supplier performance. Specifically, we suggest that CMS conduct provider satisfaction surveys, in addition to the beneficiary satisfaction surveys conducted as part of the current DME program, to provide valuable information on supplier performance and inform CMS’ decisions about the program and supplier participation.

Access to DME for Medicare and Medicaid Beneficiaries
CMS notes that, while Medicare and Medicaid generally serve distinct populations, more than 10 million beneficiaries are enrolled in both programs. CMS is concerned that the differing coverage and supplier rules may affect access to care for these dually eligible individuals, and seeks input on this issue.
UC Health commends CMS’ efforts to investigate access to DME for dually eligible individuals, who represent the most vulnerable people we serve and are the most at risk when problems occur. In fact, the problems we have described about the CBP disproportionately affect dually eligible individuals and, in our view, supersede and overshadow issues arising from discrepancies between the Medicare and Medicaid programs.

For example, individuals who are dually eligible are less likely to have the resources to compensate for a problem with equipment delivery. They may not have the financial resources to buy or rent their own equipment when it is not delivered on a timely basis, or they may be less likely to have family who can travel to pick up equipment at an alternative location. As a result, they are more likely to stay in the hospital for an extended time when delivery of equipment is delayed.

Additionally, we have recently received a few reports about Medicare suppliers who no longer accept assignment of Medicare reimbursement as payment in full, and are requesting co-payments and/or payment in full at the time of service. While a limited number of beneficiaries may be willing and able to pay for the item(s) up front and wait for reimbursement from Medicare at a later date, many will not, particularly the dually eligible. At best, this delays access as providers must identify alternative suppliers that may be located at a greater distance. We understand that CMS is monitoring this issue closely in the wake of the most recent fee schedule’s implementation, and we appreciate these efforts.

UC Health appreciates this opportunity to share these concerns with CMS. We would welcome additional discussions to resolve these issues. If you have any questions, please contact UC Health’s Director of Health and Clinical Affairs, Julie Clements, JD (julie.clements@ucdc.edu/(202)-974-6309) in UC’s Office of Federal Governmental Relations.

Sincerely,

John D. Stobo, MD
Executive Vice President of UC Health