



Talking Points on CMS-4203-NC, “Medicare Program; Request for Information on Medicare Advantage”

The Centers for Medicare and Medicaid Services (CMS) recently issued a formal Request for Information related to various aspects of the Medicare Advantage (MA) Program (87 *Fed. Reg.* 46918, August 1, 2022). Twenty years since its inception, the MA Program now has 28 million participants, representing 46 percent of all Medicare beneficiaries. It is an appropriate time for CMS to closely examine the MA Program in its “Vision for Medicare” which aims to place “the person at the center of care and drive a future where people with Medicare receive more equitable, high-quality, and whole-person care that is affordable and sustainable.”¹ Over the last 20 years, home care technology has made tremendous strides, enabling an increasing number of patients to receive safe, efficacious, and cost-effective health care at home—the site they prefer to be. Our country’s experience with the ongoing COVID-19 public health emergency has demonstrated that Durable Medical Equipment, Prosthetics/Orthotics, & Supplies (DMEPOS) suppliers have been able to take care of many patients at home, thereby alleviating hospital overcrowding.

In our comments, AAHomecare urged CMS to:

1. Improve Oversight of Medicare Advantage Plans (MAPs)

- a. Reform appeals process for MAPs that is consistent with Medicare Fee-for-Service (FFS).
 - b. CMS should provide clear guidance to MAPs that they must have coverage and documentation requirements that are no more restrictive than those of Medicare FFS.
 - c. MAPs should be required to follow all waivers and flexibilities issued during PHE and natural disasters issued by CMS.
 - d. CMS should require MAPs to publish the policies and procedures that DME suppliers are required to follow and should be no more restrictive than Medicare clinical/medical, operational, billing, ABN, and payment policies.
 - e. CMS should require use of standard remittance reason and remark coding. This will allow for appropriate denial reasons for payment by Secondary Commercial and Medicaid plans.
 - f. MAPs should be required to demonstrate to CMS that they have completed “access to care” analyses for access to DMEPOS items and services, particularly where there are a limited number of DMEPOS suppliers in a particular geographic area. Importantly, these analyses should be conducted by product category (e.g., respiratory, mobility).
 - g. CMS should designate a central contact/ombudsman with the authority and responsibility to oversee MAPs’ compliance with access to care and other requirements.
 - h. CMS should oversee MAPs marketing programs to ensure they are not misleading or false. CMS should refer reports of alleged MAP miscommunications to the appropriate state and/or federal authorities (e.g., state insurance commissioners and the Federal Trade Commission (FTC)).
 - i. CMS should require the MAPs to develop and publish DMEPOS supplier-specific (i) dashboards and (ii) reported data metrics. We request that CMS work with AAHomecare in development of these dashboard metrics.
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2. Ensure Access to Care

- a. CMS should require MAPs to establish clear network adequacy criteria by DMEPOS product category and geographic area to ensure there is real patient choice. AAHomecare would be happy to work with CMS to develop metrics that would ensure access to care. These metrics must exist for DMEPOS suppliers.
- b. CMS should ensure there is a clear channel within CMS for DMEPOS suppliers to escalate concerns when access issues are identified.
- c. CMS should ensure that MAPs establish and maintain a “same and similar” portal for DMEPOS suppliers to verify if a MA enrollee is eligible for a specific piece of DMEPOS.
- d. AAHomecare members have grave concerns about certain vertical integration arrangements that are becoming increasingly common in the market. A payor should not have common ownership in a DMEPOS supplier.

3. Provide Streamlined Prior Authorization (PA) Guidance

- a. MAPs should only have PA requirements for DMEPOS items and services when the Medicare FFS program requires PA.
- b. MAPs should eliminate PA processes for complex rehab technology service repair claims.
- c. When a MAP utilizes PAs, the MAP should have electronic and “real time” processes to ensure timely access.
- d. CMS should require MAPs to have an electronic “real time” PA system for DMEPOS items. The PA system should meet the following criteria:
 - 1) Communicated to the DMEPOS supplier within 24 hours or sooner.
 - 2) Fast track equipment/services needed on an emergency basis.
 - 3) Communication should be electronic from end-to-end, easily accessible by suppliers and free of charge.
 - 4) An affirmative PA for a DMEPOS item should be conclusive with respect to the medical necessity and payment of that item.
 - 5) An affirmative PA for a DMEPOS item should be conclusive with respect to the medical necessity for all of the options, supplies, and accessories (submitted at the same time as the underlying item) that will be used with the item.
 - 6) An affirmative PA for a DMEPOS item should be conclusive with respect to the medical necessity for (i) resupply items (e.g., for any product category that has an ongoing resupply of medical supplies) and (ii) repairs to the DMEPOS item.
 - 7) Because a PA is specific to the beneficiary, if the beneficiary moves or changes suppliers, he/she should not need a new PA for the item.
 - 8) The PA length should be consistent with the length of need ordered by the physician. A length of need of 99 should be considered a lifetime need.

4. Drive Innovation; Value Based Care Contracting for DME

- a. CMS should take steps to facilitate the inclusion of DMEPOS suppliers in Accountable Care Organizations (ACOs) and value-based programs.