CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

September 10, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

SUBJECT: CMS-1691-P, Medicare Program; End-Stage Renal Disease Prospective Payment System, 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 (DMEPOS) Competitive Bidding Program (CBP) and Fee Schedule Amounts, and Technical Amendments To Correct Existing Regulations Related to the CBP for Certain DMEPOS, Proposed Rule, Federal Register (Vol. 83, No, 139), July 19, 2018

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) is pleased to submit comments on the proposed changes to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) as outlined in the Centers for Medicare & Medicaid Services' (CMS) calendar year 2019 end-stage renal disease prospective payment system proposed rule.

CHA shares CMS' goals of transforming the health care delivery system — and, in particular, the Medicare program — by emphasizing patient-centered care and ensuring providers can direct their time and resources to addressing patient needs and improving outcomes. **We applaud the agency's steps, in both the DMEPOS CBP March interim final rule and the July proposed rule, to acknowledge some of the ways in which the DMEPOS CBP's current design limits its ability to meet those shared goals**.

California hospitals and post-acute care providers report significant difficulties in obtaining timely delivery of medically necessary durable medical equipment (DME) for Medicare beneficiaries upon hospital discharge. Since the implementation of the DMEPOS CBP, this issue has become increasingly acute. While similar challenges have been reported in both competitive bid and non-competitive bid areas across California, the frequency of delays is most problematic in CBP areas. A comprehensive approach is needed to address patients' and providers' concerns about obtaining DME.

CHA supports CMS' proposal to effectively delay the recompete process for DMEPOS CBP contracts and allow the current contracts to end December 31, 2018. This would allow beneficiaries — effective January 1, 2019 — to receive DMEPOS from any willing supplier until new contracts are awarded. This presents an opportunity for the agency to actively engage stakeholders to solicit additional ideas for program improvements, beyond the rate changes proposed, that will bring about changes that are needed. More specifically, we believe strongly that a number of changes should be made to the

DMEPOS Supplier Quality Standards, which apply to all suppliers — not just those that participate in the CBP. Further, we urge the agency to reconsider how this program is administered across the agency and look for additional opportunities to streamline oversight and increase transparency. Our more detailed comments and recommendations are noted below and in the attached issue brief.

Many Changes Are Necessary to Address Current Program Challenges

In anticipation of rulemaking, and in collaboration with CMS' Office of the CBP Acquisition Ombudsman as well as other interested stakeholders, we have worked with our member hospitals and post-acute care providers to document the challenges case managers experience daily in obtaining medically necessary DME for Medicare beneficiaries upon discharge. CHA has developed the attached issue brief, which summarizes months of data collection and provider experience, in an effort to demonstrate root cause issues that contribute to decreased access and delays in hospital discharge. **These issues cannot be addressed through payment reform alone.**

Changes to the CBP — beyond rate setting — are needed to ensure Medicare beneficiaries have access to medically necessary DME, and that DME is provided at the right time to ensure a safe discharge from the acute or post-acute care setting. Aligning performance-based metrics and creating incentives for suppliers to compete on customer service as well as price are the definition of value. Providers must no longer bear the administrative burden or costs. The goals of high-quality, affordable health care for our patients are shared goals. Therefore, we urge the agency reflect on the concerns articulated in the attached and strongly consider the following recommendations going forward.

Policy Recommendations

CHA urges CMS to consider the following short- and long-term policy recommendations to improve access to DME for Medicare beneficiaries.

- Convene stakeholders — including providers, suppliers, contractors, the Competitive Bidding Liaison, the CBP Acquisition Ombudsman, DME Medicare administrative contractors and CMS policy staff, including leadership — to discuss the root causes of program issues. A town hall, listening sessions and opportunities for dialogue between the agency and stakeholders would further inform future work, create shared understanding of the challenges and foster creative problem solving and common-sense solutions that could be considered through appropriate rulemaking and sub-regulatory guidance changes.
- Revise the DMEPOS supplier quality standards to further clarify the term "timely as agreed upon by the beneficiary and/or caregiver, supplier, and prescribing physician." Revisions to the timely delivery quality standards should, in the case of a patient discharge from a hospital or other provider, require delivery of DME items that the ordering physician determines are essential for patient safety and continued recovery prior to the patient's discharge date, as specified by the providers and ordering physician.
- Remove the reference in the DMEPOS supplier quality standards to a five-day window for order response, specifically for DME items that are needed for safe discharge to home or community.
- Increase oversight and establish transparent performance metrics for assessing whether suppliers meet each quality standard. Incorporate these metrics and reporting into future CBP contracts.
- Make transparent the process to ensure supplier compliance with the DMEPOS supplier quality standards and other program requirements, and take steps to improve agency oversight and supplier accountability.

- Make efforts to improve the DME supplier directory to assist beneficiaries and case managers in more efficiently identifying suppliers that are able to meet their needs. Improvements may include real-time equipment availability status, estimated delivery times and specific service delivery areas by DME supply.
- Reconsider the data CMS currently uses to assess CBP performance and supplier compliance. Recognize the limitations of the data — including information not captured — and identify alternative data collection mechanisms, such as provider and patient satisfaction surveys of all DME suppliers.

We remain committed to finding common sense solutions that promote program transparency, financial sustainability, improved access for beneficiaries and a reduction in the costly administrative and regulatory burden currently borne by providers in providing DME to beneficiaries.

In addition, CHA has considered the specific proposals outlined in the proposed rule and offers the following observations for consideration.

Product Category Recommendations
A common refrain by case managers across the state is frustration and added costs related to having to contact multiple suppliers for routine DME that patients often need at discharge to safely return home. These items include walkers and other standard mobility equipment, commodes and hospital beds. We agree with stakeholders that have expressed concerns about CMS' product pricing group categories, and we believe that discrete categories would promote fair and equitable payment rates. Grouping related DME products that are often requested together for safe discharge would limit the burden providers face when arranging delivery, set up and educational efforts among multiple suppliers.

Subdividing Larger CBAs
CMS seeks comments on whether certain core-based statistical areas (CBAs) should be split into smaller CBAs to "create a more manageable service area." CHA believes strongly that if the agency changes the DMEPOS supplier quality standards to ensure timely DME delivery, as requested, it may have no choice but to reconsider CBA size so that it can effectively oversee suppliers. Moreover, as noted in our issue brief, the size of the CBAs within each of these regions can be too large for the agency to detect access issues related to DMEPOS supplies. For example, within the broader "San Francisco-Oakland-Fremont, CA" CBA, beneficiaries could experience access problems in Fremont but not San Francisco. This issue is one that should be considered from both contracting and oversight perspectives.

Proposed Surety Bond Change
CHA supports CMS' proposal to require suppliers to forfeit their bid surety bond for a product category if their bid for the lead product is at or below the median of all bids in that category and they do not accept the contract.

Payments in Former CBAs During Gap Period
CMS' proposed policy to allow "any willing supplier" to provide bid items to beneficiaries in former CBAs will, we hope, open those markets up to a significantly larger number of suppliers. As a result, the volume of items any single DME supplier will be providing may decrease. We are hopeful that new entrants to the market will ease access issues. However, we are sympathetic to concerns that, in areas with only one reliable supplier, volume may decrease so significantly that the supplier would be unable

to sustain the financial losses and would leave the program. **CHA urges CMS to develop and implement an oversight program that captures the quantitative and qualitative impacts of this policy, should it be finalized, and make the data available for additional analysis and consideration in future rulemaking**.

CHA appreciates CMS staff's continued commitment to working with CHA in addressing these challenges and the opportunity to comment on the proposed rule. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688; or my colleague Pat Blaisdell, vice president continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/
Alyssa Keefe
Vice President, Federal Regulatory Affairs

Enclosure: *California Hospitals' Challenges in Obtaining Durable Medical Equipment for Medicare Beneficiaries,* September 2018.