



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

November 1, 2019

Francis J. Crosson, M.D.  
Chairman, Medicare Payment Advisory Commission  
C/O Medicare Payment Advisory Commission  
425 I Street, Northwest, Suite 701  
Washington, D.C. 20001

Dear Dr. Crosson and Members of the Commission:

At its September 2019 meeting, the Medicare Payment Advisory Commission (MedPAC) discussed the effects of the Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program (CBP) on access to diabetes testing supplies and expanding the products subject to competitive bidding in the future. The California Hospital Association (CHA) appreciates the commission's review of this program and encourages the commission to consider the additional, critically important policy issues as you continue discussions on this topic.

CHA represents more than 400 hospitals and health systems throughout California. Our members include acute care and long-term care hospitals. In addition, the CHA membership includes post-acute care providers across the continuum that are owned and operated by member hospitals and health systems. In 2018, California hospitals served more than 3.7 million Medicare fee-for-service (FFS) and nearly 2.5 Medicare Advantage beneficiaries, many of whom require durable medical equipment (DME) upon discharge home.

Access to DME is essential to ensure that patients have the necessary support to address ongoing medical needs once leaving the hospital and returning home. In addition, DME keeps patients from having to return to the hospital to manage their chronic disease and to remain active participants in their communities. While beneficiaries are able to obtain DME from Medicare participating suppliers on their own, hospital case managers play an important role as referral agents in submitting orders for medically necessary DME as part of the discharge planning process.

**Despite the important role DME plays in managing the health and well-being of Medicare beneficiaries, access to DME in California has been an ongoing challenge. We believe our experience in providing medically necessary DME in both competitive and non-competitive bid markets will provide valuable insights to the commission as it proceeds in its policy development work. CHA welcomes additional conversation on the key areas of concern raised below.**

### ***Background***

Beginning in 2017, California hospitals and post-acute care providers reported significant difficulties in obtaining timely delivery of medically necessary DME for Medicare beneficiaries upon hospital discharge—difficulties that are not unique to hospitals serving patients in competitive bidding areas. These delays increase administrative costs to the hospital and place undue burden on Medicare beneficiaries in the home. **In evaluating current DME policies like the competitive bidding program, we respectfully request that the commission take a broader view to inform the policy analysis and future**

**recommendations specific to not only the competitive bid program, but to DME policy in general. Despite the Centers for Medicare & Medicaid Services' (CMS) evaluation of the program policies to date, we believe the current evaluations are limited.** Additional work by MedPAC is critically important prior to future recommendations.

***CHA Findings of DME Access Issues Faced by Medicare Beneficiaries***

Following a year of increasing anecdotal member concerns, CHA initiated several quantitative and qualitative data collection efforts—in collaboration with the CMS Office of the CBP Acquisition Ombudsman—to document hospital and post-acute care provider case managers' experiences in obtaining DME for patients, with the goal of identifying solutions to improve beneficiary access to DME.

This effort culminated in an [issue brief](#) prepared and released in September 2018, which was shared with stakeholders including providers, suppliers, contractors, the competitive bidding liaison (CBL), the CBP Acquisition Ombudsman, DME Medicare administrative contractors and CMS leadership and policy staff. **CHA qualitative and quantitative data collection efforts and analysis uncovered a number of root cause issues that contribute to decreased beneficiary access and delays in hospital discharge. Notably, these challenges cannot and should not be addressed through payment reform alone. Consistent with MedPAC's approach to other Medicare payment and coverage policies, we believe the commission should further examine these challenges as to ensure that any future recommendation regarding expansion of the CBP take into consideration these additional policy issues.** A detailed discussion of all of CHA's policy recommendations are outlined in the attached September 2018 issue brief. Key recommendations for the commission's consideration are highlighted below.

***Significant Changes Are Needed to Modernize Current DME Payment and Regulatory Policy to Align with the Goals of Value-Based Payment and Reduced Regulatory Burden***

***Inadequate Oversight of DMEPOS Suppliers Impacts Beneficiary Access***

As detailed in the attached issue brief, CHA member hospital case managers reported and documented to the CBL situations in which staff were unable to obtain the equipment needed to ensure a timely and safe discharge from the acute or post-acute care setting. Despite good faith efforts by the hospitals and the CBL to address these issues, enforcement action to compel suppliers to provide DME in full compliance with delivery, set-up, and training requirements—as outlined in the [DMEPOS quality standards](#)—is lacking.

Notably, during the September meeting, MedPAC commissioners discussed the fact that “bad actors” may not be deterred under the competitive bid payment structure in the same way a “good actor” would be. Unfortunately, hospitals attempting to obtain DME for patients to support discharge are often faced with suppliers not meeting the quality standards required by Medicare. Despite direct engagement with CMS staff and the CBP Acquisition Ombudsman, CHA was unable to identify transparent processes for DME supplier compliance with the quality standards. Adherence and accountability to the quality standards are important tools that CMS has not fully leveraged or enforced. **We urge MedPAC to fully assess the oversight and enforcement actions available to CMS under current DMEPOS requirements and, in particular, to carefully review how accountability to the quality standards can be improved through value-based incentives.**

As the commission considers whether the CBP should be expanded to additional DME items and supplies, we urge it to consider a value-based approach, similar to other Medicare payment policies.

Specifically, as outlined in the attachments, CHA has [recommended](#) through notice and comment that CMS consider developing, collecting, and publicly reporting supplier performance metrics and adherence to contract provisions. Further, we believe that performance metrics can and should be incorporated into the CBP bidding and contracting processes.

CHA remains concerned that that some suppliers—in an attempt to lower their bids—do not adequately account for costs associated with full compliance of the quality standards and do not factor in the appropriate time for delivery to a hospital, set-up, and training in the home. Performance metrics could include timely fulfillment of DME orders and delivery, accessibility of customer service representatives, and adherence to DME supplier quality standards. In addition, similar to how hospitals and the Medicare administrative contractors are assessed, the patient and provider experience in working with a supplier should also be an important factor in determining whether that supplier remains in the program.

Prior to CBP implementation, suppliers had to compete on customer service: those with exceptional customer service were rewarded with business from case managers and beneficiaries. **Requiring standardized, publicly reported metrics for all suppliers would foster competition and improve DME supplier performance. If developed and integrated into the CBP bidding process, future supplier bids would fully reflect the level of customer service required to comply with DMEPOS quality standards, subsequently reducing administrative burden on providers and improving value for the Medicare program.**

*DMEPOS Quality Standards Do Not Ensure Timely Delivery of DME to Support Hospital Discharge*

Unfortunately, current evaluations of the CBP are limited and, we believe, flawed, due to the data being used. **Our data collection efforts demonstrated that many access issues are masked in the current claims data used by CMS to assess access to and use of DME by beneficiaries.** For example, hospitals routinely take steps to ensure that beneficiaries receive their DMEPOS and related supplies in a timely manner, despite suppliers' failure. This is essential for safe discharge. In addition, case managers consistently report that a hospital may provide a beneficiary a necessary item, like a wheelchair, at the hospital's own expense. In other cases, the hospital may delay discharging the patient until the DMEPOS supplier can provide the equipment. **Both situations not only inconvenience the beneficiary, but also result in additional expenses to the hospital and the Medicare program. Because the hospital took action, no negative health outcomes would be reflected in the claims data.**

**A number of the access issues that are masked by claims data could be addressed with improvements to the DMEPOS quality standards.** For example, the quality standards require that suppliers "deliver and set up, or coordinate set-up with another supplier, all equipment and item(s) in a timely manner as agreed upon by the beneficiary and/or caregiver, supplier, and prescribing physician." However, elsewhere in the quality standards, suppliers are allowed up to five calendar days to notify the prescribing physician and referral agents that they cannot, or will not, provide DME. This standard is inconsistent with delivery in "timely manner as agreed upon" by the beneficiary and prescribing physicians. The preferred standard of care, historically, has been to ensure delivery to the patient at the time of hospital discharge so that clinical staff can provide the necessary individualized assessment and training. Because hospital case managers typically have only 24 to 48 hours' notice of the DME prescribed, allowing DME suppliers five days to notify referral agents that they will not supply the prescribed DME adds significant administrative burden, contributes to delays in hospital discharge, and limits beneficiary access. **CHA urges MedPAC to consider how the current quality standards impede**

**timely discharge, and to engage providers on the steps taken that might mask these issues while analyzing claims data.**

Notably, since the suspension of the CBP beginning January 1, 2019, California hospitals continue to report challenges with obtaining DME in a timely manner to support hospital or post-acute care discharge to the home. While some hospitals have seen improved response times based on the ability to order DME from “any willing supplier,” timely delivery continues to be an obstacle. The recommendations noted above and in the attached correspondence have been shared with CMS and should be fully considered by the commission as it continues deliberation of DME policy.

CHA appreciates the commission’s interest in ensuring the DMEPOS CBP improves access to medically necessary DME for all Medicare beneficiaries. As noted above, CHA would welcome a conversation with the commission staff prior to the November or December meetings to share additional perspectives and insights, and to answer any questions. Under separate cover, we will reach out directly to schedule a call.

In the meantime, if you have any questions, please do not hesitate to contact me at [akeefe@calhospital.org](mailto:akeefe@calhospital.org) or (202) 488-4688; or my colleague Pat Blaisdell, vice president continuum of care, at [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org) or (916) 552-7553.

Sincerely,

/s/

Alyssa Keefe  
Vice President, Federal Regulatory Affairs

CC: James E. Matthews, Ph.D., Executive Director, MedPAC  
Tangita Daramola, Competitive Acquisition Ombudsman, Centers for Medicare & Medicaid Services

Enclosure: *California Hospitals’ Challenges in Obtaining Durable Medical Equipment for Medicare Beneficiaries, September 2018*  
*CHA Comment Letter on CY 2019 DMEPOS CBP and Fee Schedule Amounts, and Technical Amendments to Correct Existing Regulations Related to the CBP for Certain DMEPOS Proposed Rule*