JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

September 10, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1691-P
P.O. Box 8010
Baltimore, Maryland 21244-8010

Submitted electronically www.regulations.gov

Re: CMS–1691–P End-stage Renal Disease and Durable Medical Equipment, Prosthetics, Orthotics and Supplies Payment Programs

Justice in Aging appreciates the opportunity to comment on the above referenced Notice of Proposed Rulemaking (NPRM).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

I. ESRD

We strongly support the proposed reporting measure under the ESRD QIP that would track the percentage of patients at each dialysis facility who are on the kidney or kidney-pancreas transplant waiting list. We also appreciate CMS's solicitation for information on transplant and modality requirements and share the agency's concern about the failure of many facilities to fully inform every patient about all modalities and to evaluate for transplantation.

With respect to home dialysis options, we appreciate that CMS is reminding providers of their obligation to educate patients about their options, including particularly options for home care. We ask that CMS take more aggressive steps to measure compliance and take action when facilities fail to meet their obligations. Of particular concern are those facilities that do not themselves offer home-based services and thus have little incentive to educate patients about their potential advantage. We also urge the agency to ensure that payment design does not incentivize or otherwise encourage facility-based over home-based options.

Particularly concerning is the fact that services for ESRD patients present a glaring example of health disparities in Medicare. As CMS has noted, racial and ethnic minorities are less likely to be treated with home dialysis than white patients. Further, transplantation is much less available to people of color and those with low incomes. In addition to the studies noted by CMS, news reporting has shown the toll that

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that these disparities have taken on minority and low-income communities.[1] We urge CMS to continue to focus on addressing these disparities and hold facilities responsible for discriminatory practices.

II. DMEPOS

In the NPRM, CMS undertook an extensive data analysis to look at how the agency's payment policies, specifically the Competitive Bidding Program (CBP) methodologies, affected different types of suppliers in different regions and how the policies impacted access to and availability of Durable Medical Equipment (DME). It found that, with limited exceptions, the system was working well and fairly for suppliers and that beneficiaries' access was not compromised.

Advocate experience with DME suggests that the statistics CMS collected do not reflect the full picture of DME access for beneficiaries. Justice in Aging works with advocates for low income older adults and people with disabilities throughout the United States who consistently report that problems with access to DME are among the most common challenges they face with both Medicare and Medicaid and among the most difficult to resolve.

For any given beneficiary issue, provider payment policy may not be the only root cause, but it does appear that CMS payment policies have contributed to the extensive problems beneficiaries face. We urge CMS, as it moves forward with modifications to the current system, to take into account the on-the-ground problems beneficiaries face and work to ensure that payment policies address them constructively and no not exacerbate existing problems. The challenges include:

Servicing of existing equipment: Beneficiaries report great difficulty in getting repairs, adjustments, replacement batteries and other services for existing equipment. The problems exist with the original supplier and become even more acute when the original supplier is not available or when, for other reasons, the beneficiary needs to change suppliers. Although Medicare rules allow a beneficiary to use any Medicare supplier for repairs, beneficiaries often report that they cannot, in fact, find any supplier who is willing to undertake the services. This appears to be the function of a payment schedule that disincentivizes provision of these essential services.

In-home visits: A common related problem is supplier resistance and/or inordinate delay when an in-home visit is required to either repair an item in the home or collect equipment to be repaired. Advocates also report that beneficiaries have problems getting loaner equipment to use in the interim when service takes a long time. Again, we expect that payment structure contributes to this problem.

Industry consolidation: Beneficiary advocates report that the consolidation of DME suppliers over the last several years has made it more difficult to change suppliers if one is unsatisfactory. Beneficiaries put up with poor services because there are no alternatives, and they are afraid to alienate the only supplier they can find willing to provide needed items by making a complaint.

Disconnects between Medicare and Medicaid: Beneficiaries who are dually eligible for Medicare and Medicaid face additional challenges with DME coverage. For example, we hear of dual eligibles working with CBP suppliers to obtain DME and finding that, ultimately, the DME is not covered or not likely to be

[1] See, e.g., Washington Monthly, The Dialysis Machine (Nov.-Dec. 2017), *available at* https://washingtonmonthly.com/magazine/novemberdecember-2017/the-dialysis-machine/.

covered under the Medicare benefit. When the CBP supplier is not also a Medicaid supplier, the beneficiary has to start all over, finding a different supplier and beginning anew with required paperwork. Another common challenge is the transition from Medicaid-only coverage to dual eligibility, which usually involves a need to change at least some DME suppliers. Many beneficiaries are caught off-guard and experience disruptions in service. To address these concerns, we urge CMS to consider requiring that, as a condition in their contract, CBP suppliers must enroll in the state Medicaid programs in the areas where they operate. If CMS will not introduce this change, we ask that, at least, Medicaid enrollment be accorded points in the CBP bidding process. We also ask that CBP contracts require that suppliers have procedures to facilitate transition to dual status, including specifically, procedures for authorization prior to the date that the individual becomes eligible for Medicare so that there is no interruption is delivery of needed supplies.[2]

We ask that CMS develop CBP contracting policies and DME fee schedules that work to ameliorate these recurring problems and improve timely access to DME equipment, services and repairs for all beneficiaries.

III. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange

CMS is requesting feedback on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, including possible revisions to the patient health and safety requirements for hospitals and other providers.

We appreciate the efforts of CMS in developing Blue Button 2.0 and its efforts to provide beneficiaries with health information in ways that they can understand and use. We urge CMS to ensure that this and other EHR and health IT systems are designed from the outset to be fully accessible to individuals with disabilities and individuals with limited English proficiency. Integrating accessibility at the outset is the most effective way to ensure that all beneficiaries are able to see their health information and participate fully in their care. In creating regulations and guidance around interoperability and access and designing consumer-facing platforms, CMS should work closely with the disability community and provide ample opportunity for field testing and feedback from consumers, particularly those with disabilities and those with limited English proficiency.

IV. Request for Information on Price Transparency

CMS also requests comments on how to provide better price transparency for ESRD services and DME supplies. The request discusses the issue in the context of broader efforts by the agency to use transparency and consumer-friendly communications to address rising concerns about "surprise billing" faced by beneficiaries.

Justice in Aging supports price transparency in health care. Transparency alone, however, does not fully address surprise billing. Without other protections, attempts to address surprise billing or other issues

[2] See Justice in Aging's comments, submitted in response to the June 2016 Request for Information, with additional proposals with respect to DME challenges for dual eligibles, some of which are less directly related to the Competitive Bidding, available at www.justiceinaging.org/wp-content/uploads/2016/08/JIA-comments-re-DME-RFI-8-23-2016.pdf.

with health care access and costs through price transparency alone puts additional and unfair burdens on consumers to navigate even more information in an already complex system.

The Medicare policy requiring that CBP suppliers accept assignment is one critical piece of surprise billing protection for Medicare beneficiaries, and we urge CMS to maintain this important safeguard. The lack of a lack of a limiting charge for suppliers who do not accept assignment, however, is concerning. The limiting charge has been an important protection with respect to physician payments. Including it for all Medicare-covered DME would simplify transparency and provide beneficiaries with more confidence when purchasing DME.

Conclusion

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

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