Center for Medicare Advocacy
MedicareAdvocacy.org

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

August 19, 2016

Submitted electronically: http://www.regulations.gov

Re: CMS–1651–P; 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

Dear Acting Administrator Slavitt,

The undersigned organizations appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) request for information on Access to Care Issues for Durable Medical Equipment (DME). We write to express our concerns regarding a serious and persistent obstacle to obtaining DME among people with Medicaid and Medicare benefits ("dual eligibles") in many states. As representatives for dual eligibles, our organizations share a commitment to advancing the health and economic security of low-income older adults and people with disabilities.

We continue to observe that the misalignment of payment procedures in Medicare and Medicaid results in denials, delays, and higher than appropriate health care costs for essential DME among dually eligible beneficiaries. While having both sources of coverage should enhance benefits, the logistical problems created by the misalignment of Medicare and Medicaid processing rules actually lead to barriers in accessing needed care among vulnerable older adults and people with disabilities that individuals **solely** on either Medicaid or Medicare do not have.

Often, these problems arise when beneficiaries transition from Medicaid-only status to dual Medicare-Medicaid status. In these instances, individuals who previously obtained their DME through Medicaid without difficulty are now unable to locate suppliers who will serve them as dual eligibles. This is because suppliers are concerned they will not receive payment from either Medicare or Medicaid. We believe this concern is rooted in the misalignment of procedures in Medicare and Medicaid for obtaining DME, as explained below.

Unlike Medicaid, Medicare generally does not require or provide prior authorization for coverage of DME. Medicare approves or denies DME only *after* delivery of the DME and submission of a claim for payment. For non-dually eligible Medicare enrollees, DME suppliers know they can bill the patient directly if Medicare denies payment, so they generally will provide the items regardless, and then seek Medicare payment first. For dual eligibles, however, the providers know that they generally are prohibited from billing the enrollees directly if Medicare does not pay. Consequently, they are reluctant to provide the needed equipment in the first place.

Because Medicaid programs, in fulfilling their requirement to be payer of last resort, are required to avoid paying claims for which another party, such as Medicare, could be liable, state Medicaid agencies generally require that a claim be submitted to Medicare first, and only pay after there is a Medicare decision on that claim. Thus, DME suppliers generally cannot bill Medicaid until they receive a coverage decision from Medicare; but, as explained above, a coverage decision from Medicare only occurs **after** delivery of the DME. Without any assurance that the DME will be covered by Medicare, and without the ability to bill Medicaid absent a Medicare decision, many suppliers express concern that they will not be paid by **either** agency. Thus, they are understandably reluctant to deliver the needed equipment. In short, this vulnerable population, with two kinds of coverage, is left stranded without essential DME. It is important to note that this barrier to medically necessary DME is not limited to fee-for-service (FFS) Medicaid; this is a problem in managed care delivery systems, as well. Thus, the relief described below must not be limited to FFS; it must also bind Medicaid managed care plans.

Fortunately, there is a ready solution, as was adopted years ago by Connecticut, which fully addresses the above problem. In 1998, Connecticut's legislature adopted a requirement, consented to by the state Medicaid agency in response to a lawsuit brought by a dual eligible individual, requiring the Medicaid agency to process prior authorization requests for DME for Medicaid beneficiaries **whether or not they also are on Medicare**. Conn. Gen. Stat. § 17b-281a. Under this requirement, once Medicaid prior authorization is obtained for a dually eligible beneficiary, the following steps must occur: the supplier provides the item, a claim for Medicare payment is submitted and resolved, and a claim for Medicaid payment may then be made subject to any payment already issued by Medicare. This system works because Connecticut providers know that if Medicare payment is not forthcoming, the existing Medicaid prior authorization means that Medicaid payment will eventually be forthcoming. This process fully complies with the requirement that Medicaid be the payer of last resort because actual Medicaid payment will only be made after Medicare payment is denied.

Since Connecticut adopted this straightforward solution years ago, advocates there have received no complaints of DME access barriers like those that routinely continue to block access for dual eligibles in other states. Prior authorization basically works the same in every state and the Medicare program is the same throughout the country. There is therefore no reason that this simple solution cannot be adopted in every state, and thus end the needless access barriers facing hundreds of thousands of dually eligible individuals.

We request that CMS work with our organizations and other key stakeholders to adopt the Connecticut prior authorization solution. Requiring state Medicaid programs to prior authorize DME for dually eligible beneficiaries, as it does for those who receive only Medicaid, will

eliminate this access barrier that exists in many states. We look forward to working collaboratively with CMS in adopting this simple, effective solution to this serious issue for dually eligible beneficiaries.

We appreciate the opportunity to respond to the CMS request for information regarding access to DME for duals. For more information please contact Kata Kertesz, Policy Attorney at the Center for Medicare Advocacy at kkertesz@MedicareAdvocacy.org or 202-293-5760.

Sincerely,

ACCSES
Alliance for Retired Americans
American Association on Health and Disability
American Foundation for the Blind
American Network of Community Options and Resources
American Society on Aging
Aspire of WNY
Assistive Technology Law Center
Association of University Centers on Disabilities (AUCD)
Brain Injury Association of America
Californians for Disability Rights Inc.
California Health Advocates (CHA)
California In-Home Supportive Services Consumer Alliance (California IHSS Consumer Alliance)
Center for Elder Care and Advanced Illness, Altarum Institute
Center for Independence of the Disabled, NY
Center for Medicare Advocacy, Inc.
Cerebral Palsy Association of Nassau County
Cerebral Palsy Associations of New York State
Christopher & Dana Reeve Foundation
Colorado Cross-Disability Coalition
Commission on the Public's Health System
Community Catalyst
Connecticut Legal Rights Project, Inc.
Connecticut Legal Services
Disability Advocates Advancing our Healthcare Rights (DAHHR)
Disabled In Action of Metropolitan NY
Disability Rights Education & Defense Fund (DREDF)
Disability Rights Maryland (formally Maryland Disability Law Center)
Disability Rights Mississippi
Disability Rights New Jersey
Disability Rights Oregon
Disability Rights Texas
Disability Rights Wisconsin
Families USA

Gleason Initiative Foundation
Greater Hartford Legal Aid
Handicapped Children's Association of Southern New York
Huntington Hospital Senior Care Network
International Association for Indigenous Aging
Jacksonville Area Legal Aid
Jewish Federations of North America
Justice in Aging
Lakeshore Foundation
Law Office of Ellen Saideman
Legal Services of Southern Piedmont
Long Term Care Community Coalition
Medicare Advocacy Project of Greater Boston Legal Services
Medicare Rights Center
Michigan Disability Rights Coalition
Michigan Elder Justice Initiative
MSSP Site Association
National Academy of Elder Law Attorneys (NAELA)
National Adult Day Services Association (NADSA)
National Committee to Preserve Social Security and Medicare (NCPSSM)
National Council on Aging (NCOA)
National Disability Rights Network
National Health Law Program (NHeLP)
National Multiple Sclerosis Society
New Haven Legal Assistance Association, Inc.
New Yorkers for Accessible Health Coverage
New York Legal Assistance Group
Northeast Florida Medical Legal Partnership
Not Dead Yet
Partners in Care Foundation
Public Justice Center
Sargent Shriver National Center on Poverty Law
Southern Disability Law Center
Southern Tier Independence Center
Special Needs Alliance
The Bonnie Wesorick Center for Health Care Transformation
The Law Office of Nina Keilin
United Cerebral Palsy of New York City
United Spinal Association
Upper Room AIDS Ministry (URAM)
Vermont Legal Aid
Virginia Poverty Law Center
Visiting Nurse Associations of America
Volunteers of Legal Service
Western Center on Law and Poverty