**State of Vermont**
**Agency of Human Services**
280 State Drive
Waterbury, VT 05671-1000
**www.humanservices.vermont.gov**

*Al Gobeille, Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

**Date:** March 23, 2018

**RE:** Response to Public Comments for GCR 17-091: Fee-for-Service Payments for Durable Medical Equipment, Prosthetics/Orthotics, and Supplies

Comments were received from Home Medical Equipment and Services Association of New England, Keene Medical Products, Lincare Inc., The Medical Store, Vermont Legal Aid, Inc. and Yankee Medical.

A summary of comments received and the Agency of Human Services' responses to these comments is included below.

**1) Policy Effective Date**

**Comment:** Request to push back the effective date of the policy. If not the whole policy, then just the codes that don't pertain to the 21st Century Cures Act (Cures Act) of 2016. The policy became effective January 1, 2018, well before the close of the published comment period of December 20, 2017 through January 20, 2018, extended to January 22, 2018. Implementation of the policy prior to the close of the public comment period, at a minimum, undermines the credibility of the invitation for public comment and confidence that public comment will be taken into consideration.

**Response:** Prior to January 1, 2018, durable medical equipment and prosthetics and orthotics (DMEPOS) remained one of the only reimbursement systems DVHA maintained that was not benchmarked to Medicare. While not all items and services on the DMEPOS have a Medicare rate, it is operationally critical, as well as most efficient, for DVHA to update all its DMEPOS items and services at one time.

DVHA acknowledges that its timeline for adoption was accelerated as a result of the Cures Act and led to a decrease in time for providers to review proposed rates. For these reasons, DVHA will keep an effective date of January 1, 2018.

DVHA discussed its intention to benchmark to Medicare during meetings held on August 21, 2017, November 15, 2017 and December 13, 2018 with representatives of the Homes Medical Equipment and Services Association of New England (HOMES). The late release was related to a number of factors outside DVHA's control, most notably, the Centers for Medicare and Medicaid (CMS) held a technical assistance webinar on December 7, 2018, which impacted the proposed rates and contributed to the delay. In the future, DVHA will release proposed rates further in advance of their effective date. Medicare rates are public information; providers are encouraged to do their own modeling as new Medicare rates become available.

The 30-day comment period is to promote transparency and allow formal receipt of feedback on policies and practices from stakeholders. DVHA takes all comments received through the comment period into consideration and if warranted, makes retrospective or prospective adjustments. DVHA has made several changes to the policy based on feedback received throughout the stakeholder engagement process and prior to the formal public comment period.

**2) Codes Included in the Fee schedule update (CURES codes vs. full fee schedule)**

**Comment:** Specifically request that DVHA amend GCR Policy 17-091 to limit its application to only DME as defined by section 1861(n) of the Act. We recommend DVHA either maintain their current fee schedule for DME and use the reconciliation process as outlined in the recent guidance to State Medicaid Departments from the Centers for Medicare and Medicaid Services (CMS) in order to comply with the 21st Century Cures Act. However, if DVHA deems it necessary to adjust rates to comply with the Cures Act, it should adopt the 2016 Medicare Non-Rural fee schedule for the 255 codes

**Response:** Two key principles that guide setting provider payment rates at DVHA are transparency and where possible, creating methodologies that benchmark to Medicare. Mirroring Medicare creates administrative simplification for providers so that billing and payment policies for Medicare and Medicaid are as similar as possible, as well as allowing for an objective way to measure adequacy of payment across different provider types and settings.

Prior to January 1, 2018, DMEPOS remained one of the only fee schedules DVHA maintained that was not benchmarked to Medicare. DVHA's intention was to benchmark its entire DMEPOS fee schedule to a percent of Medicare well prior to the Cures Act. It is operationally critical, as well as most efficient, for DVHA to update its fee schedules in their entirety. For these reasons, DVHA will not limit its application of rate changes only to items and services as defined by section 1861(n) of the Act.

**3) Payment Rates**

**Comment:** Our comments on the substance of the policy are limited to the adoption of payment for Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) based on a percentage of the Medicare rate, specifically with respect to payment rates for prosthetics, orthotics and supplies. We understand the state is adopting this policy in response to Section l 903(i)(27) of the Social Security Act (the Act) which prohibits federal Medicaid reimbursement to states for certain durable medical equipment expenditures that are, in the aggregate, in excess of what Medicare would have paid for such items. However, this prohibition applies only to items described in section 1861(n) of the Act and therefore does not apply to prosthetics, orthotics and medical supplies. DVHA's inclusion of these items in the policy is unnecessarily expansive and will work to impose an undue burden on Vermonters seeking Medicaid coverage for these items.

**Response:** As stated above, prior to January 1, 2018, DMEPOS remained one of the only reimbursement system DVHA maintained that was not benchmarked to Medicare. It is operationally critical, as well as most efficient, for DVHA to update its fee schedules in their entirety.

In most of DVHA's payment systems that are benchmarked to Medicare, DVHA pays a percentage discount to Medicare. The DMEPOS fee schedule includes rates capped at 100% of Medicare, well above those observed in other payment systems benchmarked to Medicare. For these reasons, DVHA will not limit its application of the rate changes to only those items and services defined by section 1861(n) of the Act.

**Comment:** We are well acquainted with the difficulties Dual-Eligible Vermonters encounter when seeking access to funding for DME due to low Medicare reimbursement rates and suspect the aligning of Medicaid reimbursement rates to Medicare rates will work great hardship on elderly and disabled Vermonters.

**Response:** DVHA strives to assure adequate access to care for all its beneficiaries. DVHA actively monitors access issues surfaced through its member and provider relations unit, clinical unit and reimbursement unit. DVHA will continue to engage the provider/supplier association in quarterly meetings to review and discuss access concerns for specific items or services. DVHA has the discretion to adopt a range of policies to improve access as warranted.

In addition to comments and supporting materials received by stakeholders, the State relies on the DMEPOS subject matter experts at Medicare and those advising Congress on the Medicare Payment Advisory Commission (MedPAC) when evaluating payment adequacy and impacts on access to care. The most recent findings from MedPAC suggest that recent changes to Medicare rates have resulted in more accurate pricing and have served as an incentive against potentially unnecessary utilization of items or services.[1]

**Comment:** DVHA's use of the non-rural 2016 Medicare fee schedule as a benchmark is troubling.

**Response:** In its State Medicaid Director Letter on the Cures Act implementation, CMS explained methods states could use for setting DME rates, including applicable non-rural or rural fee schedule rates or the competitive bid rate for certain items under Medicare's competitive acquisition program, if applicable. DVHA's claims adjudication system would require substantial updates in order to pay based on geography, therefore DVHA chose to implement the use of the non-rural rate for all Vermont providers. Since Medicare pays providers nationally across a wide array of geographic regions, it relies on geographic adjustment. In other payment systems maintained by DVHA, Medicaid does not typically vary payment by geography. For these reasons, DVHA will not change its use of the July 1, 2017 Medicare fee schedule, non-rural VT rate as a benchmark.

**Comment:** The Medicare Payment rates published by CMS for 1/1/2018 are uncertain due to the Federal legislative landscape:
In December 2013, the 21st Century Cures Act also mandated that the Medicare CMS fee schedule for July 1, 2016 be RETROACTIVELY changed to eliminate cuts that occurred with that fee schedule. The legislative language required the fee schedule for 7/1/16 through 12/31/16 be retroactively changed and that the Medicare Administrative Contractors reprocess all claims at the higher fee schedule.

Currently there are two items being worked on at CMS and legislatively with Congress that will create this same situation for Vermont, therefore requiring the state, if adopting their rates to follow Medicare pricing, to reprocess claims.

1. There is an Interim Final Rule published in the Office of Medicare and Budget (OMB) to retroactively change the fee schedule for 8/1/17 through 12/31/17 to eliminate the rate cuts that occurred in 2017 and ongoing into 2018. This would make the 1/1/2018 fee schedule published by CMS that will be used for reconciliation null and void.
2. HR 4229 - Protecting HOME Access Act of 2017 has been introduced by Representative Cathy McMorris Rodgers that currently has 110 co-sponsors (and climbing) in the House of Representatives. This piece of legislation will retroactively change the fee schedule beginning 1/1/2017 through 12/31/18 again making the

[1] O'Donnell, Brian. Medicare payment policy for non-competitively bid durable medical equipment, prosthetics, orthotics and supplies. MedPAC. November 2, 2017. http://www.medpac.gov/docs/default-source/default-document-library/non-cbp-dme-final-public-(10-31-17).pdf?sfvrsn=0.

1/1/2018 fee schedule published by CMS that will be used for reconciliation null and void.

These two situations support our request to not adopt the 2016 Medicare fee schedule.

**Response:** If the legislative items pass, CMS will provide guidance to the states and DVHA will respond promptly with any changes.

**Comment:** Items that require prior authorization and are currently in process should be paid at the rates in effect in 2017. This affects companies who provide complex rehabilitative technology (CRT). The entire process for this complex equipment can take months. Providers should not be penalized for orders that began in 2017 but will not be delivered until 2018.

**Response:** The updated DMEPOS fee schedule has no impact on DVHAs billable date of service policy. Please see the DVHA provider manual, section 11.5 – Dates of service.

**Comment:** Why isn't DVHA using Rural Competitive Bidding Rates as Vermont is a rural state?

**Response:** In its State Medicaid Director Letter on Cures Act implementation, CMS explained that states could use non-rural or rural or the competitive bid rate if applicable. Vermont does not have any active competitive bid regions. Also, as described above, DVHA's claims adjudication system would require substantial updates in order to pay based on geographic region, therefore DVHA chose to implement the use of the non-rural rate for all Vermont providers. Since Medicare pays providers nationally across a wide array of geographic regions, it relies on a geographic adjustment. In other payment systems maintained by DVHA, Medicaid does not typically vary payment by geography. For these reasons, DVHA will not change its use of the July 1, 2017 Medicare fee schedule, non-rural VT rate as a benchmark.

**Comment:** The proposed rates are not sustainable for our company or any provider. In many cases, the rates will be below the cost of providing equipment and services.

**Response:** In most of DVHA's payment systems that are benchmarked to Medicare, DVHA pays a percentage discount to Medicare. This change includes rates capped at 100% of Medicare, well above those observed in other DVHA payment systems benchmarked to Medicare.

**4) Capped Rentals with Rent or Purchase Option**

**Comment:** There are a number of intricate details with Medicare capped rentals. For example, some items that are considered capped rentals can actually be purchased "day one" with certain classifications of wheelchairs. There are "rent/purchase" options available on others inexpensive items. Medicare provides clear direction for suppliers to be compliant with the rules. I can't say I feel the same with this change. The draft DME rent to purchase policy dated 10-24-17 contains information that does not appear in the policy summary GCR 17-091.

**Response:** DVHA agrees that the capped rental policies require attention to detail and appreciates stakeholder input to date on how to best mirror Medicare's policy and rates. DVHA also agrees that some items considered capped rentals can be purchased in lieu of initiation of the 10 month rental period. Following receipt of these comments, DVHA updated its systems, provider manual and issued a reimbursement banner clarifying that these items can be purchased in lieu of initiation of the 10 month capped rental period. The rates for these items reflect Medicare pricing, as advised by CMS subject matter experts.

**Comment:** DVHA is proposing to adopt Medicare's policy for capped rentals. However, there are many codes that Medicare has a purchase option as well. If DVHA does not adopt the

purchase option and only allows for rentals, this will have a disproportionate impact on complex mobility equipment users. The Association recommends including both rental and purchase rates.

**Response:** DVHA agrees that the capped rental policies require attention to detail and appreciates stakeholder input to date on how to best mirror Medicare policy and rates. DVHA also agrees that some items are considered capped rentals can be purchased in lieu of initiation of the 10 month rental period. Following receipt of these comments, DVHA updated its systems, provider manual, and issued a reimbursement banner clarifying that these items can be purchased in lieu of initiation of the 10 month capped rental period. The rates for these items reflect Medicare pricing, as advised by CMS subject matter experts.

**5) Supplies During Rental Period**

**Comment:** Regarding supplies for rented equipment, DVHA does not follow Medicare policy for CPAP equipment. Under Medicare, supplies for rented equipment is billed separately from the beginning of the rental period. DVHA's current policy includes supplies (masks, tubing and filters) with the rental rate during the compliance period (3 months) then purchases the equipment once compliance has been met. Once purchased, DVHA will pay for supplies separately. Under the proposed fee schedule, the reimbursement has been reduced from $874 to $397 (54%) and the reimbursement rate includes the cost of supplies for the 10-month rental. This is unsustainable, and the Association is hearing that if this policy is adopted, HME companies will not be able to provide this equipment.

If DVHA is using Medicare rates and guidelines, then supplies need to have a separate allowable. DVHA provider section 11; will have to be removed or modified. Providers need to be paid for supplies for rental equipment such as Ventilators, Oximeters, Compressor Nebulizers, 50 PSI Compressors, Suction Pumps and CPAP. Especially now that DVHA is proposing a 10-month cap for rental DME.

If supplies continue to be included in the 10th month rental period, we would be forced to stop taking on new rental customers for certain product lines.

**Response:** DVHA discussed this issue during the December 13, 2017 meeting with the DMEPOS provider supplier association (HOMES). DVHA agreed to model the potential impact of aligning the supply policy to Medicare using quantity limits as a proxy for new volume. DVHA continues to study the impact and does not have valid cost estimates developed at the time of the publication of these responses to comments. DVHA requested providers and suppliers submit any information on the potential volume and cost of aligning the supply policy to help expedite its review of the issue. DVHA received supply data from the HOMES group on March, 20th 2018 and will be conducting an analysis based on the data received.

Should DVHA decide to update its supply policy, following its review of valid cost estimates of the impact, DVHA will issue a notice in the Global Commitment Register as well as updated billing guidance describing any proposed changes.

**6) Policy Education**

**Comment:** It would be nice to know that once DVHA has a policy in place, they will provide some help with training/education, so everyone is on the same page.

**Response:** DVHA will hold ongoing quarterly meetings with the HOMES group. If issues arise or clarification is needed in-between meetings, please reach out to DVHA and DVHA will address those concerns and provide education as needed.