E-Alliance Extra

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In This Edition:

Update from MAHC Office

I am very excited as I finish up my first month as Executive Director of the Missouri Alliance for Home Care. I am reminded of the challenges each and every one of you face daily and want to commend you for your dedication and service to Missouri's most vulnerable citizens. As I continue to hear from members who are having issues with anything from existing rules and regulations to new and proposed rules and regulations, issues with regulators and auditors, clients, documentation, education, and the list goes on and on, I sometimes wonder how you juggle it all. I have the utmost respect for the services you provide and want to assure you that all of us here at the MAHC office are ready to help you in any way we can. Do not hesitate to contact us for any reason. We may not have the immediate answer but we will do our best to find one.

This fall I will be traveling around the state for Regional membership meetings. I am looking forward to hearing directly from MAHC members on how the Alliance can help you and the home care industry. These meetings will also be a great opportunity to network with other providers in your area and discuss issues you all face. Be watching for more detailed information on when and where the regional meetings will be held.

The home care industry's strength comes from unity of purpose and a strong voice. MAHC stands ready to help in any way we can.

3rd Quarter Medicaid Provider Education Schedule

The MO HealthNet Division Provider Education 3rd Quarter Webinar Schedule for 2016 (see August dates) is posted to the MO HealthNet website at:
http://dss.mo.gov/mhd/providers/pdf/oworkshops.pdf

NEW: PEPPER Retrieval Maps Allow Comparison By State

The PEPPER team has developed maps that display the PEPPER retrieval rate for PEPPERs accessed via the PEPPER Resources Portal for each state/territory. States on the interactive map are color-coded according to their retrieval rate. Users can click on a state to obtain details such as the number of PEPPERs available in the state via the portal, the number of PEPPERs accessed via the portal, the retrieval rate and a link to the data file for all states/territories in the nation. The maps will be updated monthly.

Map of SNF PEPPER retrievals by state
Map of Hospice PEPPER retrievals by state
Map of LT PEPPER retrievals by state
Map of HHA PEPPER retrievals by state

If you haven't accessed your PEPPER you can boost your state's rate:

1. Visit the Distribution Schedule - Get Your PEPPER page at PEPPERresources.org.
2. Review the instructions and obtain the information required to authenticate access. **Note:** A new validation code will be required. A patient control number or medical record number from a claim for a traditional Medicare FFS beneficiary with a "from" or "through" date in September 1-30, 2015 (December 1-31, 2015 for HHAs) will be required.
3. Access the PEPPER Resources Portal.
4. Complete all the fields.
5. Download your PEPPER.

PEPPER is an educational tool that summarizes provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. Visit PEPPERresources.org to access resources for using PEPPER, including user's guides, recorded web-based training sessions and a sample PEPPER. PEPPER is distributed by TMF® Health Quality Institute under contract with the Centers for Medicare & Medicaid Services.

NAHC Provides Update on Pre-Claim Review Demonstration, Model Letter of Information to Physicians

The National Association for Home Care & Hospice (NAHC) continues working to stop or change the pre-claim review project, while taking steps to prepare for it as well. For your

reference, NAHC is providing a **model notice to physicians** that agencies can use to explain what is happening to physicians who refer to home health. This article is primarily intended for home health agencies in the five states targeted for Medicare home health pre-claim reviews (Illinois, Florida, Texas, Michigan and Massachusetts). However, there may be interest in this topic in other states as well.

NAHC's logo has been included on the draft letter, and NAHC suggests you add your agency's identifying information as well. This might help get the message across to physicians that the agencies are not the party to blame for their increase in paperwork.

NAHC has not drafted a patient notice as the impact on individual patients is speculative and likely to vary greatly. Also, NAHC does not want to create patient anxiety or fear needlessly.

Beyond this draft letter to physicians, NAHC has instituted an information collection effort that will be unveiled shortly in Illinois as a starting point. The information is intended to gives us a real time "before and after" understanding of the impact of pre-claim review on resource use, billing and payment timing, patient acceptance and discharge, cash flow, and the outcome of pre-claim review requests. The data collection tool should be available shortly and NAHC will share it with you then. At this point, a number of Illinois HHAs have agreed to participate.

NAHC staff recently met with the heads of Medicare Program Integrity and Chronic Care Policy. CMS listened to NAHC's ideas, but remained committed to moving forward with pre-claim reviews, at least in Illinois. The experience there will dictate whether anything changes in the other states. NAHC made several recommendations on how to scale the project back so the workload is more reasonable. CMS seemed to like the ideas, but only as fallback actions if they find they cannot meet the workload of reviews.

While some members of Congress want to help, the national party conventions and Congressional recess have detoured their doing so. NAHC is encouraging Congress to act very soon. However, CMS continues to rebuff the "soft" efforts from Congress on all fronts. CMS announced the start of hospital star ratings this week in spite of intense Congressional opposition, so the issue now requires legislation which is not an easily accessible option at this point.

A lawsuit is still an option but one NAHC wanted to hold off on while trying less aggressive approaches. The chances of success for a lawsuit would be improved by any facts indicating that the project has triggered harm following the August 1 start.

NAHC hopes the physician information letter is helpful to agencies. If you have ideas on additional ways in which NAHC can be of assistance, please share them with NAHC's staff. It does appear that some agencies have begun to accelerate their processes for getting the documents needed from physicians so that they can quickly submit them for review. This is definitely a key factor in making the project work better for the home health agency. Another key is getting favorable review decisions, which remains to be seen.

The model physician information letter is available here.

CMS Issues Pre-Claim Review Demonstration Operational Guide

The Centers for Medicare & Medicaid Services (CMS) has issued the Pre-Claim Review Demonstration for Home Health Services Operational Guide. CMS had planned to issue the guide by June 28.

The Operational Guide does not provide much more information regarding the Pre-Claim Review Demonstration than what CMS has already communicated to providers through their fact sheet, a Special Open Door Forum (SODF) call, and the frequently asked questions (FAQs). During the SODF call, CMS stated that the Operational Guide would be a draft and open to public comment. The document appears to be a final version.

The document is 24 pages long, covers 11 subject areas and includes 4 appendices that diagram the pre-claim review request submission process and claim submissions with and without a pre-claim review.

The Pre-Claim Review Demonstration is a three year project that applies to all home health agencies in Illinois, Florida, Texas, Michigan, and Massachusetts.

Under the demonstration, the agency will submit a pre-claim review request to receive a determination regarding eligibility and coverage before submitting a claim. The contractor will review the pre-claim review request to determine whether the services meet applicable Medicare eligibility and coverage criteria. For initial reviews, a determination is to be issued within 10 business days, for subsequent reviews within 20 days.

As stated on the June 14, Special Open door Forum, CMS outlines in the Operational Guide specific information to be listed on the Pre-Claim Review request. Documentation to support eligibility and coverage for home health services must also be submitted. However, CMS does not specify what documentation needs to be submitted nor do they provide guidance regarding acceptable documentation to support eligibility and coverage to assure affirmation of payment.

Once a payment decision has been made, the agency will receive notice of the determination along with a unique tracking number (UTN) that must be placed on the final claim.

CMS states in the Operation Guide, as they did on the SODF, that for submission of a claim on a CMS-UB04 Claim Form, the UTN will be in field locator 63. For submission of electronic claims, the UTN must be submitted following the OASIS assessment data (Positions 1-18) in positions 19 through 32 of loop 2300 REF02 (REF01=G1). This claim location for the UTN originally raised concern since it is the same location for home health Treatment Authorization Code.

If a claim is submitted without a UTN the claim will be subject to a 25 % reduction in payment. CMS is providing a 3-month grace period from the 25% reduction beginning from the time the demonstration is initiated in each state.

CMS has also revised the FAQs document for the Home Health Pre–Claim Review Demonstration and added several new questions and answers.

NAHC Submits Comments on FY2017 Proposed Hospice Payment, Quality Regulations

On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued Medicare Program; FY2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1652-P), the proposed Medicare hospice payment and policy rule for fiscal year (FY) 2017. Since that time, the National Association for Home Care & Hospice (NAHC) sought input and conducted numerous discussions with hospice stakeholders on aspects of the proposed rule, and submitted comments on June 20, 2016. Given that the FY2016 rule made significant payment and policy changes for hospice, it

came as no surprise that the FY2017 proposed hospice payment rule placed most of its emphasis on next steps for the Hospice Quality Reporting Program (HQRP). In keeping with the content of the proposed rule, NAHC's comments also place predominant emphasis on planned changes to the HQRP but also provide general comments related to hospice utilization and other trends discussed in the rule. Following is a summary of comments submitted by NAHC to CMS.

Hospice Utilization, Research and Analyses, Monitoring Payment Reform

NAHC notes in its comments that growth in utilization of hospice services has slowed dramatically and requests that CMS provide additional detail that helps to identify the cause(s) of this slowdown so as to determine whether access to care is being impaired. NAHC also requests information on outcomes related to CMS' previously announced referrals of hospices to Program Integrity and other oversight bodies (these referrals were the result of data analyses conducted related to payment reform). NAHC also notes the significant increase in hospice claims submitted with multiple diagnoses and posits that this will likely continue to improve since the Hospice PEPPER now provides hospices agency-specific data on the percent of claims that they have submitted that include only one diagnosis.

CMS includes as part of the proposed rule discussion of hospice's role in Medicare end-of-life spending (including pre-hospice spending) and spending outside of hospice while patients are on a hospice election. CMS found that patients with the longest lengths of stay have lower pre-hospice Medicare spending than those on hospice service for shorter lengths of time, but that overall Medicare spending for these longer stay patients tends to be higher than spending for those on hospice care for a shorter period of time. NAHC points out in its comments that it is oftentimes more difficult to predict life expectancy for longer-stay hospice patients due to their terminal diagnosis (Alzheimer's, neurological disorders), and prior to hospice service they likely receive a mix of services weighted heavily toward personal and supportive services, which are frequently financed privately or under Medicaid. With election of hospice care the patient is then eligible for coverage of some of these services as part of the bundle of covered services. NAHC also cautions against movement toward a case-mix based hospice payment system and expresses support for payment refinements that help to incentivize appropriate timing on enrollment for hospice. Further, NAHC expresses support for monitoring of the impact of payment reform on hospices with a high proportion of short-stay patients. If the most recent payment refinements are affecting these providers negatively, CMS should work toward addressing this. NAHC also underscores the need for advancements related to processing of Notices of Election and Notices of Termination/Revocation so that patient status on hospice care is recorded in the Common Working File (CWF) on a more timely basis.

Updates to the HQRP

NAHC expresses support for CMS' recognition of the importance of the variety of hospice disciplines as part of its measures pair "Hospice Visits When Death is Imminent", but relative to the measure cautions against creation of an environment that drives unnecessary visits. NAHC recommends that bereavement coordinators and volunteers be included as part of the measures when it undergoes revisions and urges that CMS develop a definition of a visit (for purposes of these measures) that is somewhat different from the definition used for claims submission. This would mean that post mortem visits, social worker phone calls, and other services would be included as part of that definition. CMS would be required to make changes to the measure numerator but NAHC believes that it is warranted. NAHC advises that any calculations made from these measures be risk-

adjusted to reflect a patient and/or family's right to decline visits in order to maintain privacy.

NAHC raises several issues related to the Hospice Item Set (HIS) Composite measure, including advising that the scores should be risk-adjusted to reflect patients that are on service for short periods of time. In such cases, hospices must have the freedom to prioritize response to immediate needs, and may not be able to deliver all seven care processes in instances where a very short length of stay ends in death. Further, NAHC is concerned that public reporting of the Composite measures without sufficient explanation of the difference between process and outcome measures could mislead consumers, and indicates it might be appropriate to wait to publicly report the Composite measures until such time as the Hospice CAHPS findings can be reported. NAHC also expresses support for the Medicare Payment Advisory Commission's recommendations that CMS pursue hospice outcome measures and actively eliminate measures that are no longer considered good measures of quality of care.

In its comments NAHC generally supports plans to create a hospice comprehensive patient assessment instrument but asks that CMS seek stakeholder input on the instrument throughout its development. NAHC also encourages CMS to consider options for development of measures that reflect quality of care at different points across the length of stay rather than just looking at patient admission and discharge as is currently the plan. NAHC also expresses concern that the new instrument will likely be completed by skilled staff at the time of care delivery so cost estimates must take that into account.

NAHC also provides some comment on star ratings for hospice, urging that CMS not utilize a bell curve for ranking of hospice programs as this type of ranking is not generally understood by the public.

The full text of NAHC's comments to CMS on the FY2017 proposed hospice payment rule is available here.

Supreme Court Declines Review of Overtime Lawsuit

The U.S. Supreme Court declined to review the National Association for Home Care & Hospice's (NAHC) challenge to new rules issued by the Department of Labor (DoL) that provide home care aides and personal care attendants with rights to overtime pay. Specifically, the Court rejected the Petition for Writ of Certiorari filed by NAHC and other home care advocacy organizations thereby ending the legal fight to invalidate the new rules.

Last fall, the U.S. Court of Appeals for the District of Columbia reversed an earlier ruling of the federal District Court that had invalidated the rules. The challenged rules affect the "companionship services" and "live-in domestic services" exemptions from the Fair Labor Standards Act minimum wage and overtime compensation requirements. The new rules reversed a longstanding DoL policy.

"Our efforts to ensure that the elderly and persons with disabilities have full access to home care will continue," stated Val J. Halamandaris, president of NAHC. There is legislation pending in Congress that would reinstate the exemptions that had been in effect since 1975. Also, NAHC has taken steps to secure Medicaid rate support for the higher costs of overtime along with a tax credit to private pay clients.

Following the institution of the new rules on October 13, 2015, home care companies have adjusted operations through increased use of part time workers, restrictions on work hours to avoid overtime costs, and increased staff recruitment. However, these are costly changes that do not provide the optimum options for care delivery and management. Further, workers have loss income that is not offset by their rights to overtime as employees have limited work hours. Consumers now have to manage with multiple caregivers when, in the past, a single caregiver met their needs.

NAHC is also monitoring the actions of state Medicaid programs and their managed care contractors to determine if Medicaid beneficiaries and providers are disadvantaged through their actions or inactions relative to overtime costs.

Utah Caregiver Reportedly Contracted Zika Virus

According to a recent report by the Associated Press, an individual in Utah who provided care to a Zika-infected family member has contracted the Zika virus, though it is unclear at this point how the individual in fact contracted the virus.

"The new case in Utah is a surprise, showing that we still have more to learn about Zika," Centers for Disease Control and Prevention medical epidemiologist Dr. Erin Staples said, according to the Associated Press.

A subsequent report by Reuters stated that the CDC is investigating the case. "We are still doing a lot of investigation to understand whether Zika can be spread person-to-person through contact with a sick person," said Dr. Satish Pillai of the CDC, who Reuters reported is investigating the case.

The National Association for Home Care & Hospice (NAHC) has previously reported on federal guidance available to health care providers pertaining to Zika, including CDC guidance on protecting health care workers (see previous *NAHC Report* coverage available here) and Medicaid resources available for the prevention of and response to Zika (see previous *NAHC Report* coverage available here).

NAHC Report will continue to provide coverage on any updates to the currently available federal resources with regards to Zika, as well as further information on this specific case should more details become available.

CMS Open Door Forum Provides Home Health, Hospice Updates

The Centers for Medicare & Medicare Services (CMS) conducted a Home Health, Hospice and Durable Medical Equipment (DME) Open Door Forum on July 13. A summary of home health and hospice issues are provided below.

HOME HEALTH ISSUES

2017 HHPPS Rate Update Proposed Rule. CMS provided the following overview of 2017 home health rate update proposed rule:

The proposed rule implements the final year of the four year phase-in of the rebasing adjustments to the national, standardized 60 day episode payment rates, the national per-visit rates, and the non-routine medical supplies (NRS) conversion factor. In addition, this proposed rule would reduce the national, standardized 60-day episode payment rates by

0.97 percent in CY 2017 to account for nominal case-mix growth between CY 2012 and CY 2014. The CY 2017 proposed rule would result in a 1.0 percent decrease (-$180 million) in payments to HHAs. CMS is also proposing changes to the methodology used to calculate outlier payments from a cost per visit to a cost per unit model. As required by the Consolidated Appropriations Act of 2016, CMS proposes changes in payment for disposable Negative Pressure Wound Therapy (NPWT) for patients under a home health plan of care. The Act requires CMS to pay for the NPWT separately and equal to payment made under the hospital outpatient prospective payment system. CMS also proposes an update to the Home Health Quality Reporting Program (HHQRP). Lastly, in addition to providing an update on the progress towards developing public reporting of performance under the Home Health Value Based Purchasing model (HHVBP), CMS proposes several changes and improvements related to the model.

- **HHVBP.** CMS proposes the following changes and improvements to the model:
- Removes the following four the quality measures, beginning for the 2016 reporting year
    - Care Management: Types and Sources of Assistance Prior Functioning ADL/IADL
    - Influenza Vaccine Data Collection Period: Does this episode of care include any dates on or between October 1 and March 31
    - Reason Pneumococcal Vaccine Not Received
- Requires annul reporting and submission of the influenza vaccine measure rather than quarterly.
- Increases the time frame to submit new measure from 7 calendar days to 15 calendar days
- Calculates performance benchmark and achievement threshold based on the state level rather than cohorts
- Defines a small-volume cohort for performance comparison and calculation of payment adjustments as having a least eight HHAs
- Adds an appeals process to the total points score and payment adjustment to include a request for recalculation and reconsideration.
- Outlines the process for public reporting of performance related to HHVBP

CMS officials announced that agencies should expect to receive their first interim performance report this month. Agencies may access the report through the HHVBP secure portal.

HHQRP. The presenters provided an overview of several proposed changes to the HHQRP.

CMS proposes to eliminate 28 measures, and add the following four new measures as required by the IMPACT Act.

- Drug Regimen review conducted with follow-up – OASIS
- MSPB
- Discharge to community
- Potentially preventable 30 day post discharge readmission

Also in the proposed rule, CMS listed eight new measures under consideration for home health agencies.

The policy for public reporting of measures adds a review period and correction process prior to measures posting on Home Health Compare.

IMPACT Act. The presenters also addressed stakeholder engagement opportunities related to the IMPACT Act and encouraged participants to view the CMS IMPACT Act web site. One such opportunity occurring in July is the field testing of standardized data elements among post acute care (PAC) providers to test the validity of the standardized data elements and the feasibility of collecting the items in all four PAC settings. CMS also announced that it plans to conduct webinars related to the IMPACT Act activities every 8 weeks.

HOSPICE ISSUES

Hospice Payment Reform/Claims Processing Update. Claims processing staff provided an update on issues that have emerged since the two-tiered payment system for Routine Home Care (RHC) and the Service-Intensity Add-on (SIA) were instituted on January 1, 2016. These claims processing issues may be reported in your Medicare Administrative Contractor's (MAC's) Claims Issues Log. Four problems have surfaced; they are described below along with the scheduled plans to address them:

First, CMS received reports that the Common Working File (CWF) did not always identify prior hospice days that should have counted toward the episode day count. This occurred when a revocation posted prior to the final claim coming in. As a result, hospices were receiving the high RHC rate for some days for which they should have been receiving the lower payment rate. A revision to the system was implemented on May 9 and hospices should no longer be experiencing this problem.

A second issue has been occurring in the Fiscal Intermediary Shared System (FISS) system where FISS is not always using the correct date to start the episode of care day count if a previous period of hospice care was recorded. At times FISS used the start of a previous benefit period to begin the count rather than using the current benefit period (when a 60-day period had intervened). The result is that too many days are being included in the current episode of care so providers are being underpaid. A correction to this error is scheduled for July 25, after which the MACs will adjust the claims.

Two additional issues related to claim processing under the new hospice payment system are scheduled to be addressed in January 2017 (a Change Request addressing these will be issued during the first week in August). The first issue relates to circumstances under which systems are not applying all days from multiple prior benefit periods in the day count for the episode. The second issue relates to payments for the end-of-life SIA payments for certain claims. While changes to correct both of these problems have been completed by the MACs, the changes did not fully address the problems, so additional changes must be made.

Hospice CAHPS. The Hospice CAHPS survey website is: http://www.hospicecahpssurvey.org/; technical questions related to the survey may be directed to the CAHPS Hospice Survey Project Team at hospicecahpssurvey@HCQIS.org or by calling 1-844-472-4621.

Notices for non-compliance with CAHPS survey requirements affecting the FY2017 payment year have been mailed to hospice providers; if a hospice has received a notice of non-compliance and wants to request a reconsideration, please follow the instructions contained in the letter. The deadline for filing the recondition request is Friday, July 29. The following recommendations were stated:

First, as part of your reconsideration request, DO provide evidence that your hospice is compliant. If you need guidance on such information please contact the Technical Assistance team.

Second, DO include the correct CCN or provider number on your request; otherwise there will be problems with processing of your reconsideration request.

Finally, DO NOT include protected health information (PHI) or personal information about patients with your reconsideration request. These are a violation of HIPAA and CMS is required to report agencies that perform such violations.

CAHPS Exemption for Size. The CAHPS Hospice Exemption for Size form for 2018 APU is now available on the CAHPS Survey Website and will remain available until August 10, 2016, which is the deadline for submission. You MUST submit a request to have CMS consider giving you an exemption for size. Be sure to use the correct CCN with your exemption request and submit your form as soon as possible.

A list of CAHPS Hospice vendors is available on the CAHPS Hospice website. Please stay in touch with your vendor and make certain that they are submitting your data in a timely fashion. **Successful submission includes acceptance of your records by the data warehouse.**

Deadlines for submission/acceptance of CAHPS data are the second Wednesday of February, May, August, and November. CMS recommends that your monitor your vendor for performance as you would any investment -- the quality of vendor performance varies. CMS cannot accept late CAHPS data submissions, and it is the hospice that will be penalized. A hospice may gain access to the data warehouse so that it can monitor activities of its vendor on behalf of the hospice, and CMS recommends that hospices take advantage of this opportunity.

Hospice Quality Reporting Program. Between June 15 and 29 CMS sent notices related to non-compliance with the quality reporting requirements for the FY 2017 APU. Hospices receiving such notices have the opportunity to submit a request for reconsideration. Please view the following web site for more information on requesting reconsideration: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html.

A New Hospice Data Directory is now available on www.data.medicare.gov ; this directory includes information on all hospices certified by Medicare and high level demographic data for each agency. Establishment of the data directory is CMS' first step toward public reporting for hospice providers. CMS is currently actively developing a Hospice Compare website, which should be ready by mid-2017. CMS' plans are for Hospice Item Set (HIS) measures to be posted on the Compare site, and eventually will post CAHPS and other data there. Hospice providers should check to ensure that data related to their agency is correct and report any errors to the regional office coordinator.

HIS Data Submission Specifications (v2.00.0) are NOW available in draft form in the DOWNLOADS section at the bottom of the HIS Technical Information page. These specifications go into effect April 1, 2017.

A New Hospice Timeliness Compliance Threshold Report will be available beginning July 17, 2016 in the CASPER Reporting Application. This report will allow hospice providers to determine how well they are meeting the new timeliness requirement that 70% of CY2016 submissions are accepted by the deadline.

Q&A

Following is a summary of questions and answers related to hospice issues that were posed during the Open Door Forum:

Hospice Claims Processing Issues. One caller requested a written claims processing update related to hospice payment reform processing issues. CMS staff indicated that most of the MACs should have updates included under their Claims Issues Logs. A Change Request related to some corrections will be available during the first week of August; additionally, staff offered to include an article on outstanding payment reform issues and their status in a forthcoming edition of CMS' Thursday E-news.

Hospice CAHPS. When will group share calculation of how hospice CAHPS measures will be scored? CMS staff indicated that the final decision on this issue has not yet been made.

Hospice and HH CAHHPS.A participant asked is CMS would be willing to make available the number of clients (providers) per state are covered by each vendor as that may be an indicator of vendor usefulness to providers? A CMS CAHPS representative said that CMS will look into that, but suggested that the number of providers used per state will not be a determinant of the quality of work that the vendor does. CMS' Office of General Counsel is currently looking at what information CMS can make available related to vendors.

Tell CMS about Problems with Durable Medical Equipment

Consumers with both Medicare and Medicaid coverage face recurring problems getting approval for Durable Medical Equipment (DME), getting repairs, and finding reliable suppliers. DME includes many vital items, such as wheelchairs, walkers, hospital beds, home oxygen equipment, and even diabetes test strips used with a glucose monitor. After dialogue with advocates about these problems, the Centers for Medicare and Medicaid Services (CMS) recently issued a Request for Information seeking more information about problems accessing these vital forms of equipment.

This is a very important opportunity to tell CMS what isn't working and to improve access to DME. Please consider commenting and share this opportunity with others, both advocates and consumers, who can provide input to CMS.

The deadline for comments is August 23.

CMS noted some of the obstacles facing dual eligibles in getting access to DME including:

- Conflicting DME approval processes for Medicare and Medicaid
- DME access problems for people who have Medicaid first and then become eligible for Medicare
- Getting coverage for repairs, particularly getting Medicare coverage for an item originally obtained through Medicaid
- Differences between Medicare and Medicaid approved suppliers (many providers are approved for one program, but not the other)

The agency asked for examples of these problems, as well as suggestions for legislative and administrative measures that could remedy the issue.

The full list of CMS questions is here. It is very open-ended. We hope that policy advocates will talk about trends they see and specific policy changes that would help. We also hope

that consumers who can recount first hand problems will respond (but since comments are public - *please don't include personal information such as a Medicare number*).

File your comments on Regulations.gov. Directions on how to file are found here. It is simple. Comments can be short or long and do not need to be formal.

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