September 6, 2022 (Stakeholder)

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
P.O. Box 8016
Baltimore, MD 21244-8016

File code: CMS-1770-P
Submitted electronically at: https://www.regulations.gov/commenton/CMS-2022-0113-1871

Dear Administrator Brooks-LaSure:

The undersigned coalition of sixty-one beneficiary advocacy and non-emergency medical transportation (NEMT) stakeholder groups respectfully submits these comments on the proposed changes to the Medical Necessity and Documentation Requirements for Nonemergency, Scheduled, Repetitive Ambulance Services in the Calendar Year 2023 Physician Fee Schedule proposed rule.[1]

We strongly support CMS' acknowledgement that communities of color, underserved communities, and modest income beneficiaries have been "disproportionately and substantially" impacted by policy changes for nonemergent Medicare ambulance services. As noted in the proposed rule, the Final Evaluation Report by Mathematica, the Repetitive, Scheduled, Nonemergency Ambulance Transport (RSNAT) model reduced nonemergency, scheduled repetitive ambulance transport use by 72 percent and expenditures by 76 percent for Medicare beneficiaries with ESRD and/or severe pressure ulcers among beneficiaries with ESRD and/or pressure ulcers.

Beneficiaries with end-stage renal disease (ESRD) and/or stages 3-4 pressure ulcers account for 85% of all Part B RSNAT claims. These beneficiaries are disproportionately African American and Hispanic. In the RSNAT demonstration, nearly 40 percent of the Medicare FFS beneficiaries with ESRD and/or pressure ulcers were dually eligible.

[1] Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2023 (CMS-1770-P). 87 FR 45860; 07/29/2022.

Prevalence of End-Stage Renal Disease (ESRD) and Diabetes by Race, Ethnicity in United States Per One Million People[2]

	Hispanic	African American	White (Non-Hispanic)
ESRD Prevalence (2019)	3,395	6,423	1,500
Diabetes Prevalence (2018-2019)	118,000	121,000	74,000

While we greatly appreciate that CMS has identified a problem with the RSNAT model, there is no policy that CMS could implement using the cited authority for Medicare ambulance services (Section 1861(s)(7) of the Act) that will improve the health and well-being of the affected low-income beneficiaries and maintain the savings from the prior authorization model. Clarifying the use of a physician certification statement and additional medical record documentation may ensure access to those needing an ambulance level of transportation. However, it does not address Medicare's lack of coverage for an alternative, lower level of non-emergency transport.

Further, it may allow beneficiaries dually eligible for Medicare and Medicaid to use a Medicare ambulance when another lower-cost form of transportation may be appropriate and available through the Medicaid nonemergency medical transportation (NEMT) benefit. However, in the RSNAT model, there was no mechanism to connect those beneficiaries denied a Medicare ambulance service to a Medicaid NEMT service. We recommend that CMS require the Medicare Administrative Contractors conducting the prior authorization review and the ambulance providers to refer lower income beneficiaries who are denied Medicare ambulance-level service to their state's Medicaid program and its NEMT services.

It is widely recognized that partial duals need help with the social determinants of health (SDOH), but they do not qualify for those that are covered by Medicaid such as NEMT. Partial duals have only a little more income than full duals (101-135% FPL v. ≤100% FPL), but they are just as likely to have health and access issues. Nearly half (49 percent) of dual eligibles in 2019 had at least one activity of daily living limitation.[3] Providing transportation to partially dual eligibles will increase access, improve health outcomes, and reduce avoidable hospitalizations.

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[2] (a) USRDS. 2021 Annual Data Report; ESRD Chapter 1 "Incidence, Prevalence, Patient Characteristics, and Treatment Modalities." Figure 1.8; Adjusted prevalence of ESRD by patient characteristics; https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities/. (b) Centers for Disease Control and Prevention. "National Diabetes Statistics Report: 2020." Pg. 4. (c) CDC. *Diabetes.* 2019. https://www.cdc.gov/diabetes/data/statistics-report/appendix.html

[3] February 2022 MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." https://www.medpac.gov/document/february-2022-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid/

Additionally, providing transportation services for partial dual eligibles is a prime opportunity for program alignment to advance seamless and cost-effective care. CMS should add a Medicaid NEMT benefit for partial duals who are denied access to ambulance service to the RSNAT program under its Center for Medicare and Medicaid Innovation (CMMI) authority. A Medicaid NEMT benefit for this small population would be paid for through the model's savings of $1 billion over 5 years and the large CMMI budget for innovation, Medicaid NEMT programs right size the benefit by ensuring the appropriate mode of transportation for the patient's condition.

We support CMS's efforts to help beneficiaries impacted by nonemergent Medicare ambulance services policy changes. However, as the RSNAT model has expanded nationwide, more vulnerable, but ambulatory, low income beneficiaries will be denied access to Medicare's nonemergent ambulance and have no alternative transportation. We, the sixty-one undersigned organizations, encourage CMS to ensure access to Medicaid NEMT for full and partial dual eligible beneficiaries.

Thank you for your attention.

Sincerely,

AIDS Action Baltimore
AIDS Alabama
AIDS Alabama South
AIDS Foundation of Chicago
Allies for Independence
American Academy of HIV Medicine
American Association of People with Disabilities
American Association on Health and Disability
American Federation of State, County and Municipal Employees
American Kidney Fund
American Network of Community Options and Resources
American Public Transportation Association
American Therapeutic Recreation Association
Amida Care
The Arc of the United States
Association of Programs for Rural Independent Living (APRIL)
Autistic Self Advocacy Network
Center for Autism and Related Disorders
Center for Public Representation
Children's Health Fund
Community Transportation Association of America
Coordinated Transportation Solutions, Inc.
Dialysis Patient Citizens

Disability Rights Education and Defense Fund
Easterseals
Equality NC
FamiliesUSA
First Focus
Global Alliance for Behavioral Health and Social Justice
Greater Wisconsin Agency on Aging Resources
HIV Dental Alliance
HIV Medicine Association
Hudson Valley Community Services
The Jewish Federations of North America
Lakeshore Foundation
Los Angelos LGBT Center
Lutheran Services in America
Medicare Rights Center
Mental Health America
Michael J. Fox Foundation for Parkinson's Research
National Adult Day Services Association (NADSA)
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Area Agencies on Aging (N4A)
National Association of Directors of Developmental Disabilities Services
National Association of Nutrition and Aging Services Programs (NANASP)
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Healthcare for the Homeless Council
National Rural Health Association
Nevada Disability Coalition
Planned Parenthood of California
Pennsylvania Council on Independent Living
Schizophrenia And Related Disorders Alliance of America
SKIL Resource Center
Treatment Action Group
Treatment Communities of America
USAging
United Spinal Association
Wisconsin Aging Advocacy Network (WAAN)
WI Association of Mobility Managers (WAMM)