How Sole Source & Narrow Network Contract Arrangements Lessen Patient Choice and Reduce Access

Background

DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies), which is referred to as DME or Home Medical Equipment (HME), enables millions of Americans with injuries, illnesses, and disabilities to safely maintain their independence at home for a fraction of the cost of institutional care. Homecare is widely understood to be the most cost-effective method for care of individuals with chronic illness and/or disability who have the ability to maintain an independent living arrangement.

Historically, these individuals have been able to choose from a number of suppliers to select the company that can best meet their needs for products offered, services rendered, and accessibility. Traditionally, a robust network of suppliers competes on quality services and products to secure consumers' business. This model has resulted in better patient outcomes and an economical solution for payors.

Across the country, health care plans are looking for innovative, cost-effective solutions to meet members' needs. However, a developing trend across the payor landscape, particularly in the Medicaid Managed Care space, is the application of sole source and/or narrow network contract arrangements for the provisions of HME and related services. Under these arrangements, a single supplier or a small number of suppliers, is contracted to meet all of the members' medical needs for the items and services impacted. There is no requirement for the contracted suppliers to have a location in, or even near, where the plan members reside. Furthermore, there is no assessment of the suppliers' expertise in the contracted HME/services.

Cause for Concern

While sole source and narrow network arrangements have been positioned as a way for payors to maintain or improve quality of life while achieving cost savings for the plan, historical evidence of this controversial network arrangement reveals that it ultimately fails to achieve the plans' goals and puts members at risk.

Sole source contracts and narrow network arrangements have a negative impact on patients and payors by:

- **Eliminating or significantly reducing patient choice, thwarting the ability for prescribers and/or consumers to choose the best-suited supplier and products to meet members' needs.**
- **Reducing personalized patient services, leading to low patient satisfaction and potentially risking the individual's ability to live independently in their home.**
- **Decreased quality of care and adverse health outcomes, resulting in avoidable medical care and hospital readmissions and cost shifting that ultimately increase expenses.**

  The Medicare Competitive Bidding Program is an example of what can occur through the use of a narrow network of suppliers. It has resulted in "significant difficulties and delays in obtaining durable medical equipment and supplies… [putting] beneficiaries at a greater risk for medical complications that could have been avoided" according to recent research.[1] These complications result in cost-shifting, which increases the overall cost to the payor.

- **Inadequately meeting network needs, preventing timely discharge from facilities, causing systemic patient access issues, and creating severe shortages in natural disasters.**

  Inadequate measurements of contracted suppliers' capacity create dangerous vulnerabilities to members. Payors often fail to evaluate suppliers' historic capacity for product categories, thus over-estimating the availability of the single source or narrow network to meet member needs.

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The harm that stems from an anemic supplier market is exacerbated in instances of natural disasters, such as the recent flooding in Houston, Texas or the fires in California. In the case of an already short supply of companies contracted to supply essential HME, they will face additional barriers to providing care, up to and including a complete inability to provide critical HME items and services.

- **Risk of network collapse, creating gaps in service and medical complications in its aftermath.**

  When the sole source contract with Univita collapsed in 2015 due to bankruptcy, thousands of beneficiaries were stranded without needed equipment and services while the affected states scrambled to find suppliers to take on patients. As seen here, having all of the proverbial eggs in one basket endangers members and jeopardizes the sustainability of the program.

- **Disruption in continuity of care, preventing individuals from being able to obtain all needed HME, supplies, and services from a qualified supplier.**

  Analysis of the recent Health Affairs report on MCO narrow networks noted that "80% of Medicaid beneficiaries are in managed care plans and many of those people are clinically or socially vulnerable with complicated healthcare needs. Healthcare disruptions…can cause healthcare problems but that disruption 'might not be detected by existing measures that evaluate network breadth'."[2]

The detrimental effects of limited HME network arrangements are evidenced by the federal Competitive Bidding Program for Medicare. The Centers for Medicaid and Medicare Services (CMS) acknowledges low rates of payment may impact care and intervened in May 2018, noting its effect on reduced access to HME and that it "may put beneficiaries at risk of poor health outcomes or increase the length of hospital stays."

Following that revision, the ESRD Proposed Rule issued by CMS in July 2018 recommends additional reforms to the Competitive Bidding Program for concerns related to beneficiary access issues and a loss in the supplier infrastructure needed to support this growing patient population in their homes. The number of unique traditional suppliers has decreased by 33% since the beginning of Competitive Bidding according to CMS data.

The Solution

A fundamental shift is needed in recognizing the role of the HME Industry to maximize the value of health care dollars spent on those with chronic conditions in the homecare setting. The provision of HME, services, and supplies is essential for patients to be able to remain in their homes, yet sole source and limited network arrangements diminish the viability of the HME market and endanger the infrastructure that enables homecare to remain an ongoing, cost-effective solution for managing chronic health care needs.

Medicaid departments should be fully transparent and instill safeguards into the contractual arrangements with MCOs to ensure that patient access and quality is not compromised. Medicaid departments should mandate that MCOs develop an advisory panel of suppliers and vested stakeholders to weigh in prior to implementing changes. Additional requirements are needed for oversight in the contracting process and minimum reimbursement standards to ensure a healthy network.

A multi-pronged approach with payor- and supplier-focused solutions is needed to ensure network adequacy, patient choice, and the best health outcomes in a sustainable and cost-effective manner.

SOURCES

1. Leiten, Brian. *"Medicare Cost Shifting in DME—2017"*. 2018.
2. Masterson, Les. *"Study Raises Concerns About Medicaid Managed Care's Narrow Networks"*. www.healthcaredive.com. 07 June 2018. Web. 03 Aug. 2018.