States Should Not Accept Flawed Medicare Rates – February 2017

Issue

On December 13, 2016, President Obama signed into law the 21st Century Cures legislation (PL 114-255) that included a provision to limit the federal portion of funding for state Medicaid programs to the Medicare rates for Durable Medical Equipment, also known as Home Medical Equipment (HME) effective January 1, 2018. This controversial provision will create hardships for the Medicaid programs trying to serve their Medicaid population who require vital HME to maintain their independence at home and an active lifestyle in the community. States who adopt flawed Competitive Bid rates will put beneficiaries at risk and will be unable to provide DME at levels that assure efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available.

As we have seen in the Medicare Competitive Bidding Program and nationwide expansion into non-bid areas, patients have diminished access to essential HME are forced to either go without, pay out of pocket, or stay longer in hospitals and nursing homes, at higher cost, rather than convalescing at home. A recent study by Dobson DaVanzo determined that suppliers are currently only being reimbursed at 88% of their cost and that providing HME "requires corporate infrastructure and significant labor input" where the cost of goods themselves only account for 58% of total cost. The report concludes that "The [Competitive Bidding] process is fundamentally flawed in that CMS is currently paying the industry far less than the total costs incurred in providing DMEPOS goods and services to Medicare beneficiaries" and that it "has the potential to significantly impact beneficiary access to needed equipment and harm the DMEPOS Industry as a whole."

Further reductions to HME reimbursement for the Medicaid population will diminish quality, destroy the infrastructure of HME suppliers who care for the Medicaid population at home, and eliminate any projected programmatic savings by shifting those savings to facility-based care reimbursement.

Responsible and sustainable reimbursement is essential for maintaining a network of HME suppliers who enable children, adults and seniors with disabilities, injuries, and illness to safely maintain their independence at home, where it is more cost effective for the system, results in better patient outcomes, and is patient preferred. Over the past several years, many states that have cut their Medicaid reimbursement significantly to fill budget gaps saw an immediate and marked decrease in the number of active billing providers, resulting in access issues for the Medicaid population.

With reduced federal funding for Medicaid programs via the 21st Century Cures law, states must now evaluate the level of service and equipment they can provide and what must be done to protect access to this vital patient population needing HME.

Problems with Applying Medicare Bid Rates to State Medicaid Programs

Limiting Medicaid reimbursement to the Medicare Competitive Bidding Program rates has four major problems:

1. **Distinct Populations and Diverse Missions:** Medicare and Medicaid programs are drastically different. Medicare beneficiaries tend to be older, disabled, or both. Medicaid was established to cover infants and mothers, and today's coverage includes low-income individuals and dual eligible. Medicare also restricts HME access for "in home use" only, whereas Medicaid covers for use in the home and community, recognizing the need for this more active population to participate in the community. With the drastically different populations who have their own unique needs, it is illogical to assume that both Medicare and Medicaid should adopt the same policies and rates—especially those derived from a defective program.

2. **Defective Medicare Bidding Program:** Medicare's auction program is fundamentally flawed, with more than 240 esteemed economists and auction experts warning that the program is financially unsustainable and calling it the "the antithesis of science and contradicts all that is known about proper market design". In 2016, prices derived in highly populated metro bid areas like Atlanta and New York City were applied nationwide to rural and non-urban America. Without adequate reimbursement, the number of suppliers dropped dramatically in a 12 month period by 24% nationwide according to analysis of the CMS supplier database by the American Association for Homecare. These unsustainable and irresponsible price reductions have severely damaged the HME infrastructure upon which beneficiaries rely, including business closures, reduced service areas, restricted products offered, and extensive delays in getting HME. All of this makes it challenging for patients to find a supplier to provide or service their life-sustaining equipment. The low-income Medicaid population is at even greater risk without any additional financial resources to bypass the system when it fails them.

3. **Reimbursement Structure:** Medicaid programs are structured very differently from Medicare. Many states already discount their payment rates by a certain percentage off the Medicare rate, either for the fee-for-service Medicaid or the negotiated Medicaid MCO rate. For example, a state Medicaid program may statutorily pay 80% of the Medicare payment rate for items and services. In addition, other states waive the 20% beneficiary co-payment because Medicaid patients cannot afford co-payments. Still, other states combine these two provisions (i.e., the 20% reduction off the Medicare payment rate and waive the 20% beneficiary copayment amount). Likewise, some states have unique variables like sales tax and costly procedures like prior authorizations and audits that further deduct from the overall payment received for providing needed equipment and services. Therefore, many state Medicaid payment rates would be significantly below the Medicare payment rates established by competitive bidding. These drastically low payments will drive the supplier safety-net out of the market and create a high risk for an already vulnerable population to have access to medically necessary equipment and services.

4. **Geographic Variances:** Rural areas have statistically higher percentages of low income populations than their urban counterparts, and this is where the harmful impact of the Medicare rates is greatest. Medicare's auctions took place in the largest 100 metropolitan

areas of the country, but prices were not adequately adjusted when applied to their non-urban counterparts to account for the different cost variances of accessing and serving this different area. Rural America has unique attributes that have distinct costs from their urban counterparts, including employee time, fuel costs, and mileage driving to a beneficiary's home, the widely ranging geological and road characteristics requiring specialty vehicles, and sparsely populated areas that do not offer the same routing efficiencies as dense urban areas. They also do not have the same economies of scale to offset the drastic rate reductions. Essentially, Medicare has forced volume discounts on suppliers in rural areas where no prospect of increased volume exists. This will have sweeping impacts on Medicaid patients in rural areas who will lose access to their trusted community suppliers who cannot continue serving them without proper reimbursement.

States' Rights

There is no federal requirement for a state Medicaid program to tie its payment limits to Medicare rates. Except for rare cases where the state has voluntarily chosen to do so, state Medicaid programs do not have to limit their state portion funding of the Medicaid program to match the federal portion.

In contrast, states are given federal directive to set their own rates in a way that protects beneficiary access to care from a sufficient number of suppliers. As such, states can maintain or even increase its state portion to preserve funding at the current levels.

- The Social Security Act contains a directive that states must ensure that payments are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan".[1] Further, states are not subject to the "upper payment limits" for HME unlike other types of services such as inpatient hospital stays.[2]
- CMS regulations clarify that states are responsible for determining the payment levels for services.[3]

Our Ask:

AAHomecare urges the state Medicaid programs to recognize the vast differences between the national Medicare program and the state Medicaid programs and to work with representatives of the HME suppliers in their states as they consider potential avenues to address this issue in the state budget.

Sources: 1. *Id.* at § 1396a(a)(30)(A) 2. Guidance on Annual Upper Payment Limit Demonstration: https://www.medicaid.gov/medicaid/financing-and-reimbursement/accountability-guidance/index.html. 3. 42 C.F.R. § 430.0; *see also Medicaid Financing & Reimbursement*: https://www.medicaid.gov/medicaid/financing-and-reimbursement/.