



Kentucky Medicaid Access to Durable Medical Equipment is in Jeopardy

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BACKGROUND

Across the country, health care plans are looking for innovative, cost-effective solutions to meet members' needs. 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. Numerous reports point to the cost effectiveness, patient preference, and better clinical outcomes for individuals who utilize HME and services in a homecare setting.

As health care costs continue to rise, health plans are looking for ways to cut costs. It is critical for plans to leverage cost-effective solutions to meet beneficiary needs, to factor not just the front-end costs, but the impact on the overall outcomes of patients, and the potential cost shifting that occurs with reimbursement reductions in the HME sector.

Unfortunately, funding for HME has deteriorated by federal and state payors, threatening the viability of the HME Industry to continue meeting the needs of Kentuckians. Reimbursement continues to drop below the costs of providing HME, supplies, and services. A recent study by Dobson DaVanzo evaluated suppliers' costs of providing HME to end users and found that the cost of goods sold only accounts for just over half of the total cost. As a service-intensive health care partner, suppliers also provide patient education, delivery and set-up, ongoing monitoring, service, and preventative maintenance, 24-hour on call services, and more. It is imperative that funding for HME reflect these costs so that the benefit can be stabilized and strengthened to preserve patient access.

The Kentucky Medical Equipment Suppliers Association (KMESA) has met with representatives at the Department Medicaid Services (DMS) numerous times over the past few years regarding several critical reimbursement-related issues that threaten Medicaid beneficiaries' ability to obtain medically necessary HME and related services. While DMS has acknowledged the value of the HME benefit to Medicaid recipients and the Medicaid program in whole, immediate action is needed on the issues outlined below to ensure continued access for those who require HME at home.

KEY ISSUES

Medicaid Fee Schedule & Federal Funding

Recent federal legislation has limited the federal portion of funding that states receive to administer care to Medicaid beneficiaries for items/services furnished on or after 1/1/18. However, there is no federal requirement for states to limit Medicaid payment rates to Medicare rates. In fact, the Social

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Security Act directs states to set adequate payments to ensure enough suppliers exist to provide care and services for the Medicaid population.

Financial pressures from the Medicare Competitive Bidding Program for HME have already had a devastating impact on the number of Kentucky suppliers left to service those requiring HME. The program's flawed pricing methodology has proven unsustainable, with a recent Dobson DaVanzo study concluding that on average, suppliers are only reimbursed 88% of costs of providing HME. Kentucky has already lost 22.4% of supplier companies in the state, and the number of company locations has decreased 25.7% since the implementation of the Competitive Bidding Program. Limiting Kentucky Medicaid reimbursement to these faulty Medicare rates will exacerbate issues with access to care for the state's medically fragile population as the suppliers who provide essential HME continues to decline.

Despite repeated efforts by KMESA to engage DMS on the issues and its offer to partner with them to explore viable solutions to protect patients and those who serve them, the Department announced program changes without stakeholder input or notice and before the full impact of this requirement on the state has been determined.

Solution

KMESA requests that its proposal soon to be submitted to DMS be seriously evaluated and considered. This proposal was garnered from an evaluation of the state's HME utilization information as it assesses the federal funding impact on the state and what options there are to ensure patient access to HME and services while complying with state requirements. Further, KMESA seeks greater transparency in communications regarding proposed program changes and advance notice before DMS takes actions that impact the supplier community.

MCO Fee Schedules

Kentucky Medicaid partners with Managed Care Organizations (MCOs), who are responsible for ensuring that their covered lives have access to timely, quality HME, supplies, and services. In October 2017, Kentucky regulations were modified without supplier stakeholder input or advance notice which granted MCOs the ability or option to set their own rates for HME and to not follow Medicaid rates.

Last year, KMESA met with DMS in March, June, and October as well as having Medicaid and MCO representatives at their Annual Conference in August to discuss challenges with MCOs changing fee schedules without notice and reimbursing less than the Medicaid fee schedule. However, DMS personnel did not offer any comment or information regarding proposed amendments to regulation 907 KAR 1:479 "Durable Medical Equipment Covered Benefits and Reimbursement", which was amended in October. This provision thwarts the state's ability to instill important safeguards to ensure that rates are sufficient enough for suppliers to continue to be able to meet beneficiaries' needs.

Solution

KMESA requests that DMS amend 907 KAR 1:479 Durable Medical Equipment Covered Benefits, Section 10 to strike the word "not" so that it states, "A managed care organization shall be required to reimburse the same amount as the department reimburses for a service or item covered pursuant to this administrative regulation."

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Beneficiary Co-Pays

Medicaid beneficiaries are financially burdened by the co-pay that they are responsible for to be able to receive medically-necessary HME, supplies, and services under the Kentucky Medicaid program. Unlike other health care providers, HME suppliers are at greater risk of not being able to collect co-payments from beneficiaries for items provided. Home delivery and shipping of HME items recur monthly, as customers rarely come to the HME location to get their products. Suppliers face an undue responsibility for attempting to collect co-payments for monthly rentals or supplies from members and have little recourse but to make efforts to remove the medical equipment from their homes and discontinue service if the co-pays cannot be collected. In contrast, providers like physician offices and pharmacies are able to obtain the co-pay up front before services are rendered, thus mitigating risk of non-payment and avoiding costly and time-consuming efforts in collecting monies due.

Solution

KMESA requests that DMS remove the beneficiary co-payment requirement for HME and instead reimburse suppliers at 100% of the Medicaid program fee schedule.

MSRP/Cost-Plus Pricing

Previously, Kentucky Medicaid provided a cost-plus 20% reimbursement for miscellaneous coded items and MSRP pricing for specific codes as indicated in the 907 KAR 1:479, Page 5-6 Section 8 (c) 1-3. Recent updates in the KAR removed the MSRP less discount for those specific HCPCS that are mainly customizable complex rehab technology products and accessories utilized with these products. Removal of this reimbursement model for these items fails to factor the large additional costs of services, including freight/shipping costs, clinical ATP services, and business operations while making the claims submission process more cumbersome and expensive. For Complex Rehab Technology, ATP labor times range from 8 to 20 hours per wheelchair.

Payor Issues

- Increases cost of claims processing by adding upwards of 20 pages of paperwork per claim for many DME requests
- Slows order processing since every claim and/or prior authorization must be manually processed, which decreases the utilization of efficient electronic submissions
- Inconsistent pricing for identical HME among various suppliers
- Penalizes larger, more efficient, and more experienced suppliers with lower reimbursement
- Incentivizes suppliers to sell HME at a higher cost

Supplier Issues

- Fails to factor operational expenses into reimbursement, thus forcing suppliers to provide at a substantial loss
- Slows reimbursement
- Results in inaccurate payments since true cost varies depending on the suppliers' contract with the manufacturer.

Overall downward pricing pressures have dramatically reduced the number of suppliers able to meet beneficiary needs, particularly with specialty suppliers like individually configured and highly

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customizable Complex Rehab Technology where the service component is even greater than the already service-intensive average HME item provided. All of these issues make it more challenging for Kentucky Medicaid beneficiaries to receive timely access to the HME, supplies, and services they need.

Solution

KMESA recommends that DMS reinstate the items removed in the KAR 1:479, Page 5-6, Section 8 (c) 1-3 which allows for Cost plus pricing for items billed with miscellaneous HCPCS and for the previous method of payment of MSRP Less Discount pricing when setting reimbursement rates for HCPCS previously specified in the regulation.

Communication Breakdown

Suppliers are receiving contradictory information from DMS and MCOs when issues such as denied claims arise. For example, MCOs deny claims for “exceeding quantity limits” for supplies and are not following the states quantity limitation guidelines. Providers have been advised to complete MCO Complaint Forms for the issue since DMS has stated that it is unaware of problems. However, after following this guidance, suppliers are reprimanded by DMS representatives for sending the complaints and told that it’s not something DMS can do anything about since it’s the supplier’s contract with the MCO. This is an unacceptable response, as the DMS contract with the MCO clearly states, “The Contractor shall provide Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program.”

Solution

KMESA recommends that DMS and MCO have consistency in responses and provide suppliers with avenues for issue resolution. Further, DMS should hold MCOs accountable for obligations in the contract agreement and intervene on behalf of suppliers as necessary to enforce contract requirements. Complete and accurate communication between suppliers, DMS, and the MCO plans is necessary for ongoing program improvement and ensuring patients receive the equipment, supplies, and services needed.

CONCLUSION

The issues outlined above create unnecessary and cumbersome hurdles for suppliers to successfully care for Medicaid beneficiaries in a homecare setting. A collaborative partnership between DMS and the supplier community can foster better outcomes for all parties through a culture of increased communication and transparency and by working together to resolve issues that arise. DMS and KMESA share the same goals of quality care and increased efficiency, and KMESA respectfully requests DMS’ consideration of the proposed solutions that will foster better patient care for those requiring HME across the Commonwealth.

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