HOMES
Home Medical Equipment and Services Association of New England

Via priority mail

July 22, 2016

Stefanie Nadeau
Director, Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011

Re: MaineCare adoption of Medicare July 1st reimbursement cuts

Dear Ms. Nadeau,

I am writing on behalf of the Maine members of the Home Medical Equipment and Services Association of New England (HOMES) to express our concerns regarding the adoption of the Medicare Durable Medical Equipment (DME) reimbursement cuts that went into effect on July 1, 2016. Our understanding is that MaineCare adopted these payment cuts to bring DME reimbursement in line with new Medicare DME payment amounts based on the DME competitive bidding program. We believe that there are a number of policy and procedural issues that need to be considered with respect to these cuts.

Maine is the only state in New England, and possibly the country, to adopt these egregiously low rates. HOMES believes that MaineCare's adoption of these rates is premature and will likely lead to problems accessing medically necessary equipment and supplies. Our reasons and concerns are listed below.

By way of background, HOMES is the regional trade association that represents home medical equipment (HME) and supply companies in the six New England states. Our members are part of the continuum of care. Their services reduce healthcare expenditures by facilitating hospital discharges and by keeping the chronically ill and disabled safely in their homes out of nursing homes and other high cost facilities. We estimate that 75% of MaineCare recipients receive their products and services from a HOMES member. It would be a mistake for MaineCare to assume that DME reimbursement would be sufficient as long as it cover providers' costs for equipment.

Our members truly are key participants in a care continuum that could not be effective without the DME provider's services. It is a grave misconception to characterize DME providers as purveyors of commodities. HOMES members are highly service oriented. This is why chronically ill and disabled individuals can stay out of costly institutions and can participate in their communities. National surveys of DME providers have quantified that equipment acquisition costs are only a small component of the total cost of serving persons who use medical equipment and supplies.

Equipment acquisition costs account for only about 30% of the costs of servicing patients. The overwhelming majority of their costs, 70%, covers the services inherent in servicing patients. These include delivery, educating the recipient and/or caregivers on the use of the equipment, 24/7 on-call service for certain items, access to respiratory therapists, obtaining extensive documentation, billing, collections, among others.[1]

The equipment, services and supplies our members provide are medically necessary and prescribed by a doctor. All of these services are included in the reimbursement rate for the equipment. There is no separate payment or billing code that allows providers to bill for these services. The new rates MaineCare implemented only cover 60 to 65% of providers' acquisition costs for the DME. On its face this is a significant reimbursement gap that providers have no way of closing and one which almost certainly eliminates their ability to provide the service MaineCare recipient need to use DME safely in their homes. These new payment reductions to DME threaten providers' operational viability and the welfare of MaineCare recipients.

The new DME reimbursement rates threaten access to appropriate care and promise to increase health care expenses in Maine.

The direction MaineCare is taking undermines the overriding goals Medicaid programs should be working towards: reducing costs and promoting efficient quality services by keeping recipient in their homes. In 2005, former Secretary of the Department of Health & Human Services, Michael Leavitt said, ***"We need to change the basic construct of Medicaid to allow for home and community care to be used. It's not only where people want be served, but it's radically more efficient. And it doesn't mean that we are not going to be spending money on healthcare but it means we are going to be in a place where we can in fact serve more people."***

To see how the new rates are in fact a step backward for MaineCare; one that will ultimately lead to increased healthcare expenditures in Maine, take CPAP[2] as an example. Obstructive sleep apnea (OSA) results in the partial or complete collapse of the upper airway during sleep. Symptoms of OSA include daytime sleepiness, fatigue, headaches, and cognitive impairment. OSA can lead to serious health risks, including but not limited to: hypertension, increased risk of stroke, congestive heart failure, coronary artery disease, and increased risk of being involved in a motor vehicle accident.

OSA was clinically recognized more than 30 years ago and is considered today to be a major public health problem in the United States.[3,4] The prevalence of OSA in North America is estimated to be as high as 1 in 5 adults for mild sleep apnea (defined by the Apnea-Hypopnea Index (AHI) ≥5) and 1 in 15 for moderate to severe sleep apnea (defined by AHI ≥15).[5]

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[1] See A Comprehensive Cost Analysis of Medicare Home Oxygen Therapy, Morrison Informatics, Inc, prepared for the American Association for Homecare, June 27, 2006.
[2] CPAP is the acronym for "continuous positive airway pressure" devices.
[3] Guilleminault C, Tilkian A, Dement WC. The Sleep Apnea Syndromes. *Annu Rev Med* 1976; 27: 465-484.
[4] Institute of Medicine of the National Academies. Sleep Disorders and Sleep Deprivation: An Unmet Public Health Problem. Washington DC; National Academies Press 2006.
[5] Young T, Peppard PE, Gottlieb DJ. Epidemiology of Obstructive Sleep Apnea. *Am J Respir Crit Care Med* 2002;165: 1217-1239

The most cost-effective, and preferred form of therapy, is the use of CPAP to open the upper airway.[6]

CPAPs must be used every night. If OSA is not properly treated, the patient is at a greater risk of developing hypertension, heart disease including heart attacks and heart failure, stroke and diabetes. By the time a person has the prescription in hand for a CPAP machine, the State will have paid thousands of dollars in doctor's visits and sleep studies. The key to effective treatment is a mask that is comfortable for the patient. It is not uncommon for the patient to work with the HME provider to try a few different masks until they find one that is comfortable for them. This is important to increase success with compliance. If the mask does not fit properly or is uncomfortable, the patient will not be compliant and ultimately end up with other medical consequences previously mentioned. The new reimbursement rate for CPAP masks is at or ***below*** the provider's cost for the types of masks that typically provide the most comfort and lead to better compliance rates. Why would the State pay thousands of dollars to qualify a patient with a diagnosis of OSA, which includes the cost of a sleep study, only to provide equipment and supplies that will not lead to the best medical outcome? The HME provider must work closely with the patient to make sure they are compliant with this therapy in order to be reimbursed. If the patient is not compliant within 3 months, ***the provider is not paid***.

Medicare DME reimbursement rates should not be adopted by MaineCare.

Rural areas were not part of the HME competitive bidding process

As you may know, the Affordable Care Act (ACA) mandated the implementation of the DME competitive bidding rates to areas where bidding did not occur. Rather than implement the full reimbursement cut on January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) divided the roll out of these cuts into two waves. The first wave on January 1, 2016 was a combination of 25% (on average) of the 2015 DMEPOS fee schedule and 25% (on average) of the competitive bidding rates; the second wave was the implementation of the current competitive bidding rate. To further compound the issue, CMS did not implement the Round 2 competitive rates; it implemented the Round 2 Recompete rates which are even lower than the original Round 2 rates.

HME providers in non-competitive bidding areas (we will refer to them as rural areas) were not part of the bidding process, only metropolitan areas were selected. If rural providers were part of the bidding process, we speculate that it would have resulted in higher reimbursement. The costs to provide HME and supplies to rural areas are substantially more than metropolitan areas. Maine providers are not able to make multiple deliveries in one day which would reduce the expense of delivery. Due to industry consolidation, HME providers have large service areas. It is not uncommon for these providers to drive one hour or more (one way) to deliver equipment on the mainland or to the islands by ferry or mail boats. Because providers must accept assignment for MaineCare beneficiaries, these new rates (which in some cases are 50% - 80% below the 2015 Medicare fee schedule) are, in many cases, equal to or less than the cost of the product making it impossible for providers to deliver the necessary services.

[6] Gay P, Weaver T, Loube D, Iber C. Evaluation of Positive Airway Pressure Treatment of Sleep Related Breathing Disorders in Adults. *Sleep* 2006; 29 (3): 381-401.

Medicare policies differ from Medicaid.

When HME providers apply for a Medicare supplier number, they have the option of being a "participating" or "non-participating" provider. Participating providers must accept assignment; non-participating providers do not. Most, if not all, of our members are Medicare non-participating providers. If Medicare's reimbursement rate is not adequate to cover all costs (which include cost of the product, obtaining extensive medical documentation, repeated interaction with doctor's offices if the paperwork is not correct, education, delivery, claim submission, etc.), non-participating providers can charge Medicare beneficiaries their usual & customary rate and submit a non-assigned claim on their behalf to Medicare. The beneficiary would be reimbursed 80% of the Medicare rate (the beneficiary has a 20% co-payment). This will lead to increased out-of-pocket expenses, difficult for many beneficiaries who have limited income.

Medicaid providers are required to accept assignment. When MaineCare adopts the July 1st Medicare reductions, it will be difficult or impossible for HME providers to provide products and services to MaineCare members. One example are TENS (Transcutaneous Electrical Nerve Stimulation) units where the reimbursement on July 1, 2016 is **638% lower than the 2015 Medicare fee schedule.**

Medicare and Medicaid serve two different populations.

The Medicare population is predominantly elderly and in many instances homebound while the Medicaid population are infants, children, adults and dually-eligible (have Medicare and Medicaid coverage). This population in many cases are active in their communities and require this equipment/supplies to go to work, church, etc. Medically complex people may need to be admitted to higher cost facilities such as hospitals and nursing homes as a result of these lower rates.

Medicaid programs are not required by law to adopt rural rates until January 1, 2019.

Section 503 of the Omnibus spending bill that was passed in December 2015 limits Federal Medicaid reimbursement to States for durable medical equipment (DME) to Medicare payment rates but this reduction is **not mandated until January 1, 2019**. States are not required to adopt the Medicare rates before January 1, 2019 and as stated above, no other State in New England has adopted these rates. Since the Federal match has not been reduced, we believe that the reduction in rates is premature.

The most vulnerable MaineCare recipients are at risk of not having access to equipment.

The most vulnerable population in Maine will likely be at risk of accessing medical equipment and supplies. People with ALS, MS, MD, etc., who require more complicated wheelchairs and accessories are one example. **HME providers may not be able to accept orders for MaineCare beneficiaries.** Additionally, if they can provide the items, MaineCare beneficiaries may be required to pick up their equipment from the provider or wait until the next scheduled delivery in their area which may be weeks or longer.

Clarification of the KU modifier

In December 2015, Congress passed S. 2425 (Patient Access and Medicare Protection Act) which delayed for one-year the application of competitive bidding rates to complex rehab technology accessories used with Group 2 power wheelchairs. In order to by-pass the competitive rate for these items, providers use the KU modifier for these codes. Please clarify that MaineCare is following Medicare rules for these items.

Medicaid recipients must have access to the same care that dually eligible Medicaid recipients receive.

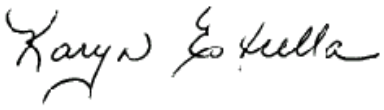
Medicaid programs must provide the same products and services for that dually eligible Medicaid recipients (people with both Medicare and Medicaid) receive[A1].

The July 1st fee schedule reflects rates that you would anticipate if you were shopping on Amazon. As noted above, these new rates are retail rates for equipment only. They do not include payment for the expenses of providing medical equipment. Our members do not merely drop medical equipment off on someone's porch – they make sure the patient qualifies for the item the doctor prescribed, collect the appropriate documentation to support the item and all the other related services we have previously mentioned. We believe that MaineCare should reverse the new DME payment amounts.

Based on the concerns we raised above, we request that you reverse the January and July 2016 DME payment rates MaineCare implemented and reinstate retroactively the rates that were in effect on December 31, 2015.

We further request a meeting with you to discuss in greater detail the above issues and to provide you with additional information and analysis regarding the new rates. I will contact you to arrange for a time for us to meet at your earliest opportunity. Thank you for your consideration and we look forward to hearing from you soon.

Sincerely,



Karyn Estrella
President & CEO
Home Medical Equipment and Services Association
of New England

cc: Governor Paul Lepage
Mary C. Mayhew, Commissioner
Beth Ketch, Customer Service and Health Care Management Director
Senator Eric L. Brakey, Chair, Health and Human Services Committee
Representative Drew Gattine, Chair, Health and Human Services Committee