OAMES Response to Ohio Department of Medicaid Oxygen Rules Proposal

October 11, 2013

OAMES' position on "bundling":

- OAMES members who specialized in custom seating systems for nursing home residents had a severe financial impact on their company, many laying off staff and making operational cuts;
- OAMES stayed in the "bundling" fight for four years because of the harmful impact on Ohio's most vulnerable population, the nursing home residents who required these services for their mobility and quality of life;
    - OAMES, the Multiple Sclerosis Society of Ohio, therapists, nursing homes and residents and other stakeholders, provided evidence of access problems to the complex seating systems benefit caused by the "bundling" policy change effective 8/01/2009;
    - OAMES met with legislators and Medicaid officials to discuss "fixes" (rule revisions, form changes, enforcement by Dept of Health and Medicaid, etc.) but no results;
    - During the last four years, OAMES did not take a position, nor have evidence, that there were access problems to oxygen services in nursing homes caused by this policy change.
- When the Ohio Department of Medicaid staff "unbundles" wheelchairs/custom seating, they should work with OAMES to focus on restoring the benefit and addressing any utilization issues which drove the unbundling policy initially.

Oxygen therapy – important to understand homecare vs long term care model:

- Significant rate reductions may be sustainable in the long term care setting but not homecare.
- The homecare oxygen benefit is a fundamentally different care delivery model with separate cost-drivers and patient demographics than long term care oxygen;
    - Nursing home oxygen patients have 24-7 oversight with clinical staff readily available in one setting for multiple patients;
    - Home oxygen therapy requires 24-7 emergency availability to multiple patients in individual homes throughout a large service area;
- There is a significant cost difference between the serving the younger more mobile Medicaid consumer and the aging, less active Medicare consumer;
- In nursing homes, according to 2008 Medicaid utilization data, code E1390 is 85% of the spending in the homecare oxygen benefit and 99% of the spending the nursing facilities.

Differences in the Medicare vs Medicaid home oxygen patient:

- Almost 60% of Medicare spending in the oxygen benefit is for patients on nocturnal only.
- It is a flawed assumption to believe that Medicare bid rates are valid and sustainable:
    - CMS-designed bidding program is widely refuted by market auction and industry experts
    - Bids were not binding causing disastrously lowball bid rates;
    - CMS issued contracts to non-licensed suppliers, violating their own bidding rules and displacing compliant bidders from the program (OIG currently conducting "limited scope review" of four states, Ohio included)
    - Bids were awarded at median rates, not the clearing rate, which means that half of bids were higher than what CMS set as the single payment amount;

- With a phased roll-out, the impact of the program on patients and other categories of spending in the health care sector will take years, not months, to be revealed;
- Program is called "suicidal" because HME companies signed contracts with unsustainable bid rates:
  - To preserve local relationships with referral sources (even at a loss)
  - With hope that the program would be stopped eventually given growing Congressional action and pressure to repeal or delay
  - For disreputable business purposes (i.e. plan to sell business, no intention to operate at the bid rates)
  - Due to ignorance of the HME operational and clinical regulatory requirements.

Historic review of Ohio Medicaid recent cuts on DME spending:

- Series of cuts made from 2009-2010 – DME/supplies expenditures dropped from $156.3 million (1.78% of Medicaid spending) in 2009 to $125.7 million (1.33% of Medicaid spending) in 2010; **a 20% reduction in DME spending.** The following outlines the key changes:
  - Cuts to incontinence supplies implemented <u>in lieu of selective contracting</u> negotiated between OAMES and Ohio Medicaid:
    - **$2.1 million savings** - Reduced monthly max quantity allowed
    - **$1.3 million savings** - Reduced reimbursement by 10% on adult products
  - Cuts to "Community provider" rates (later when this was reversed, <u>DME was exempted</u>)
    - **$285,921 savings** - Reduced enteral rate from minus 20% to minus 23% of AWP
    - **$272,067 savings** - Reduced items without set fees from 75% to 72% of list price or 150 to 147% of providers invoices
  - Cuts made to align with Medicare rates
    - **$3.4 million savings** - 36 codes cut to 95% of Medicare fees after CMS implemented reductions to certain products. Items included glucose strips, humidifier, bed side rails, five oxygen codes and 36 wheelchair/accessory codes
  - Spending reductions in two fee-for-service DME product lines due to "bundling" of ancillary services in nursing home payments
    - $**14 million savings -** complex/custom seating systems
    - **$8.8 million savings** - oxygen therapy
- Savings on dual eligible consumers from competitive bidding rates
  - Round 1 Rebid effective January 1, 2011
  - Round 2 effective July 1, 2013

OAMES recommendations:

- Preserve homecare – there are significantly greater costs in homecare and we'd recommend a measurable reduction in the long term care rate for oxygen concentrators and very nominal, if any and with the condition of certain rules changes, for homecare rate.
- Recognize that the portable oxygen modalities need increased while stationary may be decreased. There's been a subsidizing of the portable systems on the stationary systems.
- Tighten regulations on patient consumption – there needs to be finite parameters on consumption to control providers' costs and the program's utilization.
- Make changes to the Certificate for Medical Necessity (CMN) to reduce providers' administrative costs for compliance