Ohio Senate Finance Health and Medicaid Subcommittee Testimony on Substitute House Bill 166

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Chairman Hackett, Vice Chair Huffman, Ranking Member Thomas and members of the Senate Health and Medicaid Subcommittee, good morning and thank you for allowing me the opportunity to testify on behalf of the Medicaid beneficiaries and Durable (Home) Medical Equipment providers in Ohio. My name is Laura Williard and I am the Vice President of Payer Relations for the American Association for Homecare. We are the national association representing DME providers and manufacturers across the country and we partner with the Ohio Association of Medical Equipment Services (OAMES) to support their initiatives in Ohio. I am testifying to encourage your support of amendment HC2371 to Substitute House Bill 166.

In my role at AAHomecare, I have been honored to collaborate with the Medicaid programs across the country in working to ensure the 73 million beneficiaries in the United States maintain access to quality and cost-effective medical equipment, supplies and services. DME, enables 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 and includes a wide range of products and services from medical supplies to life-sustaining equipment and technology.

OAMES has a long-standing collaborative relationship working with the Ohio Department of Medicaid that I have been privileged to be part of during recent federal changes impacting the Medicaid budget. I have seen a collaborative partnership that has resulted in outcomes that have focused on quality patient care while providing clear policy, appropriate reimbursement and efficient processes for providers and payers.

Across the country there are consistent themes of issues with the managed care payers that have put quality patient care at risk. These managed care plans have created programs that have put cost savings above quality outcomes and have created an unstable environment for these patients and providers. A lack of oversight enforcing consistent medical policies, authorization guidelines, and processes create issues in continuity of care across the managed care plans and have created access issues and service delays for these patients. Unfortunately, the stance of the Ohio Department of Medicaid in allowing these managed care plans to develop their own processes, policies and rates have created these same issues we are seeing across the country with your Medicaid beneficiaries in Ohio.

Amendment HC 2371 addresses these issues by ensuring that the HME benefit under Ohio's Medicaid managed care program is consistent with the Ohio Administrative Code chapter 5160:10 and does the following:

- Requires Medicaid managed care plans to follow the specific medical policy, medical necessity criteria, claims adjudication methods and standards, coding, max quantity limits and other general guidelines, and use of certificates of medical necessity (CMN) forms;

- Ensures HME providers are paid at the rate set by the Ohio Department of Medicaid;
- Prohibits sole source contracting to preserve patients' and prescribers' choice of providers;
- Establishes an HME Advisory Group comprised of representatives of each of the MCPs, ODM and OAMES to meet at least twice annually to review and address issues as needed.

All of these rules, regulations, policies, and rates were established as reasonable by the Ohio Department of Medicaid to ensure patients received the quality services needed to remain in their home. This amendment simply ensures that the regulations and rates already established and proven to be sufficient at ensuring access to care are utilized by the managed care plans. Across the country the managed care plans were sold and implemented as a cost savings to ensure continuity of care for a patient and to reduce the overall healthcare spend. Unfortunately, these plans have changed their models on evaluating the entire healthcare needs of these patients and are now focusing solely on eliminating cost, therefore eliminating the continuity of care.

Sole sourcing has also become a growing business model that is plaguing our industry and impacting quality services. Under this policy, managed care plans enter into sole source contracts, forcing patients to use a single provider for specific products. In many instances, these companies may not even be located in Ohio. We're seeing this approach is very problematic for a number of reasons: it increases prescriptive requirements, complicates and fragments care coordination, raises concerns about transparency and accountability, eliminates patients' and prescribers' choice of the HME provider best suited for the patients' medical needs, reduces personalized patient service leading to low patient satisfaction, creates access problems to community providers which are critical in natural disasters and puts local jobs at risk.

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 that put beneficiaries at a greater risk for medical complications that could have been avoided. These complications result in cost-shifting, which increases the overall cost to the payor. This program has also created an environment where 32% of the DME providers in Ohio from 2010 to 2018 have had to close their doors.

There is history of these sole source arrangements collapsing. When the sole source contract with Univita collapsed in 2015 due to bankruptcy, thousands of beneficiaries were stranded without 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.

These managed care issues are consistent across the country creating a need for legislation to fix the problems created by these models. Last month, the Kentucky General Assembly took action and passed HB 224 to reform the HME Medicaid managed care program recognizing many of the same issues Ohio providers are experiencing. I was honored to be a part of this process in collaborating with the state legislators and the Kentucky Medicaid Program to have this bill passed unanimously in both the House and Senate and to became law on March 27, 2019.

From a spending perspective, according to an actuary report prepared for the Joint Medicaid Oversight Committee in Oct 2016, per member per month annual growth is estimated at approximately 3% per year through 2019. The HME sector has actually declined over the past decade. In evaluation of Medicare and Medicaid spending in various states it has been proven that the DME spend is ONLY about 1% of the overall Medicaid budget. Furthermore, the 21st Century Cures Act implemented last year provides prudent spending controls for Medicaid DME rates in ensuring that the overall spend for DME does not exceed what Medicare would spend for the same services. OAMES and AAHomecare worked with the Ohio Department of Medicaid to adjust HME rates last year to comply with the new law. An annual reconciliation of these rates will continue to ensure that the DME spending will remain in line with market rates.

Sole source arrangements have only proved to save money for the managed care plans, and it has not been shown that these savings have been passed on the state in their Per Member Per Month rates paid by the state.

AAHomecare and OAMES remain committed to working with the state legislature and the Ohio Department of Medicaid to ensure access to quality HME services while being fiscally responsible with the state's budget. The quality services allowed by these providers allow patients to remain in their homes where their quality of life is enhanced. Please support these efforts by passing Amendment HC2371. Thank you and I'm happy to answer any questions.