Senate Finance Committee

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Testimony on Substitute House Bill 49

Honorable Chairman Oelslager and members of the committee:

I appreciate the opportunity to testify before you today about language in Substitute House Bill 49 that greatly impacts Medicaid patients receiving durable medical equipment – often called home medical equipment – in their place of residence.

Specifically, we have serious concerns about new language that sets the maximum Medicaid payment rate for durable medical equipment, orthoses and prostheses provided January 1, 2018 to July 1, 2019, to not exceed the "Ohio-specific Medicare rates" for those services in effect on July 1, 2017. There is additional language which allows the Department of Medicaid to establish rates that exceed the Medicare limit except DME providers, treating us differently from all other non-institutional Medicaid providers. We are singled us out as the only category of healthcare services that has a payment cap while allowing the Department to make decisions about appropriate rates for all other services.

I am currently the president of the Ohio Association of Medical Equipment Services (OAMES) which is a state trade association comprised of approximately 95 company members. These businesses range from small, regional and national DME providers, to retail pharmacies, from mom-and-pop operations to global manufacturers and distributors. I'm co-founder of Central Ohio Specialty Care located here in Columbus with service areas throughout the state.

In addition to limiting Medicaid's flexibility in setting rates for DME, section 333.183 of the new bill, includes troubling language that "the Ohio-specific Medicare rates" that is the source of our concern. We are unclear exactly what that means. In recent years, the Center for Medicare and Medicaid Services (CMS) implemented a controversial "competitive bidding" program that has created nine different Medicare rates for DME throughout Ohio – eight bidding area which include Cincinnati, Cleveland, Akron, Columbus, Youngstown, Toledo, Dayton and section of southern Ohio/northern Kentucky. In 2016, CMS applied additional cuts to non-bid areas thus there is no "Ohio specific" rate as noted in the language. Suffice to say, Medicare's DME payment model is now very complicated, based on numerous fee schedules with varying calculations and different regions that is quite complex leaving us little understanding what an Ohio-specific rate would be.

Today, the DME provider community – which plays an important role in providing an alternative to institutional care at a cost savings to healthcare payers with better health outcomes for patients – is at risk given the impact of the reimbursement reductions resulting from the Medicare bidding program. According to CMS' data, we are seeing a rapid reduction of DME suppliers throughout the country, more than 34% fewer suppliers in Ohio alone from July 2013 to April 2017. CMS's DME bidding program is fundamentally flawed as attested to by more than 200 market auction experts that have not only caused problems for Medicare beneficiaries, but the DME providers in our communities who are

serving them and the medical professionals ordering and prescribing these services. We are seeing closures, staff lay-offs and reduction of services to customers. Many in the Ohio Congressional delegation have actively engaged in bi-partisan manner to modify the bidding program givens its negative impact on Ohio's providers and the people they're serving.

Earlier this year, our national group, the American Association for Homecare, retained Dobson DaVanzo to conduct a cost study to better understand the true cost of providing DME services as it compares to the bidding-derived rates. The study concluded that on average, all DME in the bidding program were reimbursed at 88% of overall cost. Furthermore, the cost of goods accounts for just over half of the overall cost of providing DME to Medicare beneficiaries. The Medicare "competitive bidding" process has been controversial in its implementation, with detractors arguing that, by design, reimbursement resulting from bidding does not cover providers' costs. The results of this survey demonstrate that bidding program is indeed likely to be endangering the stability of the DME market upon which millions of Medicare beneficiaries rely. This instability is a result of Medicare payments that are at levels consistently below the cost of supplying the products and services.

Furthermore, it's important to understand that the Medicare and Medicaid programs are drastically different, serving distinct populations and diverse missions. 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 DME 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. It's also important to note that these are the most vulnerable and dependent members of our society of who need access to these services that keep them at home. I have with me today one of our clients, Linda Eckfeld, who along with her husband Tom in the Canal Winchester area, have adopted numerous medically fragile children and can speak to the effects of these changes on her kids and her family.

In conclusion, we request that the new language in Sec. 333.183 be removed that ties Ohio Medicaid rates to Ohio Medicare rates which are based on a controversial bidding program. This is not acceptable for a state Medicaid program trying to serve their Medicaid population who require vital DME services to maintain their independence at home and an active lifestyle in the community. We also respectfully request removal of language in Sec. 333.180 and not to be singled out as the only non-institutional care provider that restricts the Ohio Department of Medicaid from exceeding Medicare limits if they feel it is necessary for rates that assure that efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available.

Thank you for your time and consideration. I look forward to working with all of you to solve this issue and will be happy to answer any questions.