March 2, 2020

To the Blue Ribbon Commission,

The Midwest Association for Medical Equipment Services & Supplies (MAMES) is an 8-state regional association that represents the durable medical equipment (DME) and medical supply providers in Minnesota, and 7 others states in the Midwest: Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota and Wisconsin.

MAMES is writing in response to the Blue Ribbon Commission’s two strategies, #419 and #420, impacting Durable Medical Equipment (DME) and medical supplies.

I. Strategy #419: Volume Purchasing Durable Medical Equipment

This strategy requires DHS to expand the use of volume purchasing to additional types of DME products, including enteral nutrition, wound care supplies, and standard wheelchairs and walkers. DHS anticipates costs savings of $1M to $9,999,999.

MAMES opposes this strategy for the following reasons.

Spending on DME and supplies is not a cost driver, as the total spend on fee-for-service DME and supplies is estimated to be only $87 million in SFY 2020-21 (per the BRC January 14, 2020 handout, slide 48). Total spending on fee-for-service health care by DHS is projected to be in excess of $12.3 billion in FY 2019 (per the BRC October 10, 2019 handout, slide 47). Fee-for-service represents 25% of this total (per BRC January 14, 2020 handout, slide 19), so fee for service spending exceeded $3 billion in 2019. This means that spending on DME and supplies constitutes less than 3 percent of fee-for-service budget.

DHS states it is currently volume purchasing, oxygen, hearing aids and diabetic test strips. These items are very different from the other equipment and supplies they are proposing to volume purchase.

Most of the items listed, like wheelchairs and walkers, are already set by a volume purchase program -- Medicare’s competitive bid program (CBP). That pricing established the upper payment limit for Medicaid federal cost sharing for those items addressed by the 21st Century Cures Act. As a result of legislation in 2019, Minnesota Medicaid has reduced payment rates on those items to Medicare rates, including walkers, wheelchairs, hospital beds and other common DME items. DME providers would not go below what is already the lowest fee schedule for those items included in the Medicare CBP.

Enteral nutrition, which had been included in the initial rounds of Medicare competitive bidding, was specifically excluded for the 21st Century Cures Act upper payment limit, presumably because the enteral food prices that had resulted from the competitive bid process, caused significant access issues for Medicare patients who needed enteral nutrition.

The statement included in the Strategy #419, “Individuals who access health care services through Medical Assistance and MinnesotaCare fee-for-service and utilize the DME products that are volume purchased will be minimally impacted. These individuals may have different brand options covered but similar products will be available” is simply not true. This is evidenced by the issues stated below with the fundamentally flawed Medicare CBP as acknowledged in recent rule changes by the Centers for Medicare and Medicaid Services (CMS):
CMS implemented a 2-year gap between January 1, 2019 to December 31, 2020 in the Medicare CBP to address the rule changes.

CMS specifically recognized that the access issues created by the Medicare CBP rates were especially damaging to rural areas, so it created a separate fee schedule for rural areas that has much higher reimbursement for CBP items.

Despite the rural relief, and as documented in the GAO report released December 2018, the number of suppliers of DME is continuing to decline. According to our national Association’s ongoing study on the estimate of number of DMEPOS suppliers and locations, there was a -37% loss in the number of Unique Supplier Companies in the US between 2010 (when the CB program began) to October 2019, which included the loss of the second largest supplier in Minnesota back in 2018.

In addition, the Medicare CBP and its pricing expansion nationwide has had a tremendous impact on DME providers and access to DME and medical supplies. Below are two studies on the Medicare CBP from Dobson|DaVanzo, a leading consulting group focused on healthcare economics and policy:

- **DME Cost Study**: the study was done to determine the real impact Medicare’s competitive bidding program is having on quality of care, reimbursements and overall costs. One of the key findings shows that Medicare reimbursement rates for home medical equipment cover just 88% of overall costs for companies providing the service.

- **DME Access Study**: it was discovered that competitive bidding “negatively affected beneficiaries’ access to DME services and supplies, adversely impacted case managers’ ability to coordinate DME for their patients and placed additional strain on providers to deliver quality products without delay.”

The unsustainable price reductions have severely damaged the DME infrastructure upon which patients rely, including business closures, reduced service areas, restricted products offered, paying for items out of pocket and extensive delays in getting DME and supplies. *The low-income Medicaid population is at an even greater risk if further reductions result from the proposed volume purchase expansion, for they likely do not have any additional financial resources to bypass the Medicaid system when it fails them.*

Finally, in 2017, DHS conducted a volume purchase program for adult incontinence products. There was an *exhibit presented on the unsustainability of the volume purchasing program for incontinence products*. The exhibit showed the costs of doing business and the losses providers would experience if the program was implemented. DHS was sued during implementation of the program, and subsequently, in 2019, the Minnesota Legislature passed a law prohibiting DHS from volume purchasing incontinence supplies.

MAMES requests the Blue Ribbon Commission recognize that DME is already at the lowest fee schedule due to Medicaid using the Medicare CBP fee schedule for a majority of items. Any attempt to do further volume purchasing would not save any money because providers would not go below the rates already being reimbursed by Medicaid. MAMES requests the Blue Ribbon Commission reject Strategy #419.

### II. Strategy Healthcare #420: Modify certain Medical Assistance Durable Medical Equipment Payment Rates to Match Medicare Rates.

This strategy modifies Medical Assistance fee-for-service payment rates for select DME and supplies. DHS states that currently, the rates are based on a methodology outlined in administrative rule and are calculated in a complex manner that is based on a percentage of billed charges. DHS indicated a projected savings for this strategy between $1M to $9,999,999M.

MAMES opposes this strategy for the following reasons.

Outside of a few categories within DME and medical supplies, Medicaid is currently paying Medicare rates due to legislation passed in 2019. The language directs DHS to set the Medicaid payment rate equal to the Medicare payment rate for all DME items that are subject to the Medicare DME upper payment limit (UPL), which CMS established under the 21st Century Cures Act. DHS began implementing this requirement effective for dates of service on or after July 1, 2019.

In Minnesota and throughout all states, Medicare has three payment rates:

1. a rate for certain large metropolitan areas where CMS’s competitive bid program was used to establish rates;
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(2) a rate for non-rural areas outside of the competitive bid zones; and
(3) a higher rate for zip codes deemed rural by CMS.

DHS applies each of these rates, depending on the zip code of the Medicaid client which designates the rate. Currently DHS is only reimbursing at non-rural and competitive bid rates and is working to have its system reprogrammed to accommodate the rural rates.

Further reductions to DME reimbursement for the Medicaid population to the items not already reduced to the Medicare fee schedule will devastate all providers who care for the Medicaid population. Providers would no longer be able to provide the same products and services where the reimbursement does not cover their costs. In addition, it will eliminate any estimated Medicaid program savings by shifting those savings to long-term care expenses.

The Minnesota Legislature has repeatedly recognized that Medicare and Medicaid programs are drastically different. Medicare beneficiaries tend to be older, disabled, or both. Medicaid covers infants and mothers, low-income and dually eligible individuals. 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.

MAMES requests the Blue Ribbon Commission recognize that Medicaid is already paying Medicare rates and that no further savings could possibly be obtained. MAMES requests the Blue Ribbon Commission to reject Strategy #420.

IN CLOSING

The Blue Ribbon Commission was directed by the legislature to “not include in the action plan recommendations that may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.”

MAMES believes if the Commission proceeds with Strategies #419 and #420, it would negatively impact access to DME and medical supplies for a vulnerable population. If DME and medical supplies are not available through the Medicaid program because no provider can carry the items due to reimbursement that is less than costs, it would result in significantly reduced access to care for thousands of Minnesotans, including many of its most vulnerable citizens.

DME and medical supplies, like wheelchairs, oxygen, enteral formula, feeding tubes, and incontinence products, etc., enable millions of Americans with disabilities and chronic illnesses to remain safe and independent at home and in their communities. Providing these products is an essential cost benefit tool for keeping the overall costs of health care down. The more that people receive quality medical equipment, supplies and services at home, the less that is spent on hospital stays, emergency room visits, and nursing home admissions.

Thank you for your consideration.

Respectfully,

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