MISSISSIPPI DIVISION OF MEDICAID

Public Comments

SPA 20-0001

Durable Medical Equipment (DME) and Medical Supply Reimbursement

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From David Hosemann:

Hello Margaret, hope your well. Here are my comments.
1)public notice (par.1) states that these fees go into effect 3/1/20. In the past the fee schedule changes have always taken place 7/1. Why is this schedule different?
2) Some of the fees come in below our cost. Some of the fees come in at discounts from previous fees @ 35% to 20% from current (incontinence products). At least 1 fee is unchanged (A4253). What method was used to arrive @ the change in fee schedule?
3) Define "market research" method of pricing.

02/11/20

Dear Ms. Wilson,

I appreciate the opportunity to comment publicly on the proposed fee schedule for Medicaid providers of durable medical equipment. It seems to me that roughly 30 days is hardly enough time to consider serious commentary about the changes, but it is my intent to try.

The economics of healthcare are indeed difficult for us all – the State, hospitals, physicians, ancillary providers like us, and for patients. Services must be provided at a reasonable cost, but also at a reasonable margin for the provider. Medicaid provides one of the lowest margin reimbursements in the healthcare spectrum already. So when additional LARGE cuts are made official with the stroke of a pen, as in the case of these proposed cuts, I fear that the outcome will be fewer providers, less access to the equipment patients need, and thus a less healthy population. The approach to these cuts is short-sighted

and I fear an unintended, yet detrimental, effect on the already-stressed medical equipment community in Mississippi.

Thank you,
Ronnie Sleeper
Med Supply Center, Inc.
Corinth, MS

2/12/20

Hello Mrs. Wilson
I understand wanting to do away with manually price ideas but the pricing that was chose is a joke. Most items are at or below our cost with no consideration for labor, delivery fees or overhead. Now today I saw the pricing for batteries and repair items and the are worse then the list of original items. Almost all are below my cost. I need to know is there going to be a good faith effort to fix pricing or who's number should my customer and referral sources call when we can't supply their needs?
thanks
Rick Deaton
Mobility Medical

2/13/20

February 14, 2020
Margaret Wilson, Division of Medicaid, Office of the Governor, Office of Policy
Walters Sillers Building Suite 1000

Re. Opposition to Mississippi State Plan Amendment 20-0001: Durable Medical Equipment (DME) and Medical Supply Reimbursement

Dear Margaret Wilson:

This letter is to request MS Medicaid's retraction of SPA 20-0001 submitted by the Division of Medicaid. I'm writing as the Chief Operating Officer of a durable medical equipment business.

General Access Concerns: Difficulty in Providing Mississippi Beneficiaries with Access to Medically Necessary DME.

Over the past 10 years, Mississippi DMEPOS providers have experienced significant rate cuts under Medicare. Current rates have resulted in a significant lack of access to medically necessary equipment and supplies relied upon by beneficiaries.

From November 2010 to October 2019, Mississippi has experienced a 31% reduction in the number of DMEPOS suppliers. Some providers have gone out of business abruptly, leaving the remaining suppliers scrambling to prevent any gap in service to beneficiaries.

Jones County Medical Supplies, Inc has been in business since 1978 and has five locations across south Mississippi. With all of these loss of suppliers, we are the only DME company in four of the five cities we are located. In the fifth location, Hattiesburg, we have seen a large amount of suppliers close their doors. This trend of suppliers closing will only continue to increase with more reimbursement cuts like this.

Mississippi State Plan Amendment 20-0001

The changes being proposed within this state plan amendment will be completely devastating to Mississippi. Although Medicaid is allowing for a thirty-day comment period, no hearing is being allowed to be held. Mississippi DME providers have faced so many cuts over the last 10 years which has translated into 31% of suppliers going out of business.

Durable Medical Equipment is one of the most effective segments of healthcare. DME providers keep patients out of hospitals and nursing homes, where care is dramatically less costly. There are endless problems with the changes in the fee schedule, but can be divided into two categories.

Category 1- Making manual priced items to a fee schedule.

The prices that have been assigned to the previous manually priced items are completely unsustainable. I can understand the desire to eliminate manually priced items as much as possible, but there is no way that most of the items will be able to be provided to patients any longer. Here are some examples of this:

- HCPC- B4088 Feeding Tubes- The proposed fee schedule for this is $28.93. There is a huge difference in costs in feeding tubes. Most of this comes from the type of patient. Feeding tubes for pediatric patients cost a great deal more than feeding tubes for adults. This is why a manually priced item in the case of this fee schedule is much better option than assigning a fee schedule. This would still allow for patients to get the items, while still controlling the costs. Our company has many pediatric patients across south Mississippi. We have looked at the new allowables and will not be able to provide any of our patients with feeding tubes. On average we would lose over $100.00 per feeding tube. A feeding tube is a device that is essential to live. When patients can no longer get a feeding tube, they will be forced to go to hospitals to receive to get new feeding tubes. This will only increase costs for Medicaid. Instead of it costing anywhere from $100-$200 this will cost Medicaid several thousand dollars in a hospital visit.
- HCPCs A7520-A7522 Trach Tubes- The proposed fee schedule for these items is in the low $40.00 range. This is the exact same as the feeding tubes above. These allowables are unsustainable and will not allow any supplier to provide these items. This will only cost Medicaid more in the end as patients will be forced to go to the hospital to get their life sustaining trachs replaced.
- HCPC A4606 O2 Probe- This proposed fee of 17.09 is also unsustainable. This is a probe that is used to measure patient's oxygen saturation level. This is also a life sustaining device and the cost is unsustainable.
- HCPC E0641- Standing Frame Table Systems and the other Sit to Stands- Standing devices are designed to provide medical and functional benefits to a person who is unable to stand independently. These benefits include addressing medical needs, improving body structure and function, as well as increasing activity and participation. The devices are used by people of all ages and may be a standalone piece of equipment or can be incorporated into a manual or power wheelchair base. These devices must be individually assessed and configured by a CRT provider. These providers are specially trained and the process takes multiple evaluations and assessments of the patient. The prices that have been set for these items is way too low. Our company would lose $1000.00 on average per unit when looking at the ones we provided in 2019. These are devices that help very sick and disabled adult and pediatric patients live their lives more fully and provide great health benefits. The allowable that have been assigned would not allow any provider to do these items any longer, therefore, removing a great health benefit to patients.

Category 2- Decrease in incontinence fees- Lowering the incontinence fess will cause multiple problems. The largest problems, is that DME providers will have to start carrying a less costly product. These products will lead to poor incontinence management which will ultimately lead to greater healthcare costs. Conditions such as untreated incontinence associated dermatitis leads to pressure injuries, which leads to significant healthcare costs to Medicaid. Poor incontinence management also leads to nocturia, which is the leading factor in nighttime falls as well as urinary tract infections. My fear in lowering reimbursement of incontinence is that Medicaid will pay more in conditions that will be caused from providers using inferior products.

In Summary

I respectfully request that Medicaid Retract Plan Amendment 20-0001. I truly believe that these changes will cause significant problems for Medicaid patients and will lead to greater costs for Medicaid. As I stated above, since we are the only provider in four of the five cities where we are located, there will be no one else to provide these items to patients.
Thank you for your kind consideration of this request.

Respectfully,
Matthew Boyd,
Chief Operating Officer, Jones County Medical Supplies, Inc

Hello Mrs. Wilson
I sent my new battery pricing effective 2/01/20 and Medicaid's new rate so you could see how bad the pricing is. Please keep in mind the batteries cost is only the beginning. We have to send techs out to do the work and have people to do all the billing and paperwork. There are a few cheaper battery companies then MK but their quality is lower and I would have to send techs out more often. Either way you are asking us to service these truly needy people at a loss. The pricing on new chargers and repairs are just as bad in many cases. I know Medicaid used the pricing from 6 Southern states to get a lot of the new prices but didn't care that some state have codes and prices for items they don't cover so no one care that there underpriced. I'm also curious how the Medicaid Can programs started this pricing already.
thanks
Rick Deaton

2/18/20

February 13, 2020

Dear Mississippi Medicaid,

This letter is to let you know how very concerned I am regarding the cuts taking place in the incontinence field provided to your patients who rely on your knowledge of necessity.
You have cut gloves and wipes out of the program. These items provide safety from germs and viruses for the patient as well as the caregiver.

As of March 1, 2020, you will be cutting allowables on all incontinence supplies for your patients. This will eliminate your patients and their ability to have supplies that will keep down the spread of germs and viruses. This is a mandatory issue in light of the deadly Corona Virus and other diseases facing the State of Mississippi and the United States of America.

It is of great disappointment that because of employees of our State, who were unchecked that constituents must suffer.

There must be a better solution than punishing patients for this gross crime. This includes children and adults who rely on your Mississippi Medicaid Plans and have been on these services for many years.

Thank you for looking into this matter,

Mary Thomas

02/18/20

Ms. Wilson

We are very concerned with the proposed pricing of manually priced items on the upcoming Fee Schedule change proposed for March 1, 2020. We have been servicing Ms Medicaid beneficiaries for over 40 years and would like to continue, but most of the prices on this fee schedule are significantly below our cost and are not going to allow us to continue to service these beneficiaries with the quality of products and services which they are accustom to receiving from Jones County Medical Supplies, Inc and our 4 other branches. Also, this is a very short notice for such drastic changes in reimbursement for some of the most costly supplies which we provide.

Paula Breland
Office Manager
Jones County Medical Supplies, Inc
104 South 13th Ave
Laurel, MS 39440
(601)426-2574 Ext. 143

02/18/20

Ms. Wilson,

It is with serious concern that we are contacting you today. The proposed adjusted DME and Medical Supply Reimbursement fee schedule will have *significant impact* on the hundreds of Mississippians that we serve each month. And, although there are many, MANY concerns, our biggest concern is over 2 particular life sustaining items that serve the most fundamental functions – **breathing and eating**!

Among a host of medical supplies and equipment, we provide Gastrostomy Tubes (**B4088**) necessary for enteral nutrition, and Tracheostomy Tubes (**A7520 / A7521**), required for managing airway, for the most critical patients,

including children, throughout the state of Mississippi. Fortunately, we live in a time where these patients are discharged from the hospital and their patient care is able to continue in the home setting. As the DME and medical supplier, we process and ship these life sustaining supplies directly to the patient each month for their ongoing care. If we were unable to do this, the patient would have to RETURN to the hospital for tube placement or changes. Returning to the hospital increases infection risk and incurs unnecessary expenses.

Most importantly, we do NOT "select" which G-tube or Tracheostomy tube the patient will get; this is directed by the surgeon who operated on the patient! The type and brand of G-tube and Trach Tube supplies we provide to the patients are a direct result of **what the physician/surgeon placed for the patient in surgery as to what is best for them!** The cost of these supplies/items is beyond our direct control and is set by the manufacturer at an industry level. As it stands today, the Medicaid fee schedule allows for us to submit these as "Manually Priced Items", submit our actual invoice/true cost, and be reimbursed accordingly.

If Medicaid makes changes to the proposed fee schedule rates on March 1, 2020 as proposed (A7520 @ $43.74; A7521 @ $43.33; B4088 @ $28.93) we will be **UNABLE TO PROVIDE THESE PATIENTS WITH THESE ITEMS.** In some cases, our COST for these items is **10 TIMES the proposed rate**! What is the patient supposed to do? Is someone addressing this with the surgeons and physicians who care for these patients? Do they understand the impact POST DISCHARGE?

Since we have been in business for 20 years, we have the benefit of MULTIPLE manufacturers and distributors from whom we can get product from. We work diligently to get the most cost-effective products and shipping rates (**WE absorb these shipping costs**) from multiple suppliers. We are more fortunate than other suppliers to have this ability, and we pride ourselves on being able to provide our patients with the best care. However, even with our best negotiations, we will not be able to supply these patients at the reimbursement rates proposed.

Making these changes will certainly cause patient care to deteriorate and hospital costs to increase as more patients are forced to return to the hospital for these items. We are asking that you **RECONSIDER** these changes so that we will be able to maintain patient care at home and decrease hospital/ER admissions.

Respectfully,

Health Care Medical

02/20/20

Children's of Mississippi

February 21, 2020

To whom it may concern.

My name is Hanne Nanavaty, I am the trach nurse/educator at the children's hospital. I am writing this letter over concerns from providers, caregivers and DME companies, over the recent reimbursement change per Medicaid starting March 1st 2020 to reduce the reimbursement for the tracheostomy tubes/ breathing tubes for the DME companies to an amount that will not cover the actual cost of each tracheostomy tube needed.

The correct size and type of tracheostomy tube is carefully selected to meet the needs of the child. Some children need a standard size breathing tube, some might need a longer or shorter breathing tube, and some need one that has a balloon at the end of the tube. It all depends on the anatomy of the airway and specific reasoning for needing a breathing tube. Some children are in need of the silicone trach tubes, others might be fine with breathing tubes made with PVC and some might need custom tracheostomy tube due to the anatomy of their airway. These trach tubes are all different, some can be reused up to 5 times but are very expensive, others are only for single use and less expensive, but due to the need for trach tube changes they will need 2-5 trach tubes monthly.

The children are completely dependent upon their caregivers to maintain their breathing tube and resolve any issues. If a trach tube becomes plugged (mucous plugs) or accidentally comes out, they will need a replacement right away. This must occur within minutes or the child could die.

The current practice at other children's hospitals as well as here at the children's hospital at UMMC is to change the tracheostomy tube weekly and as needed. The children's airways are much smaller than on adult. As a result, the breathing tubes are much smaller and secretions can easily buildup causing mucous plugs. The result will be that they cannot breath and as said above death can occur. I am very concerned that if the DME companies are not reimbursed for the cost of these tracheostomy tubes, then they will no longer supply our children with the needed breathing tubes and this will create several issues:

- Increase in Infections
- Frequent hospitalizations/ increase cost
- Other complications including death

Thank you so much for your consideration in this matter of reimbursement to the DME companies for the cost of the needed tracheostomy tubes. If you have any questions, please do not hesitate to contact me.

Sincerely,

Hanne Nanavaty

Hanne Nanavaty, RN Pediatric
Trach Nurse/Educator
Children's of Mississippi
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02/21/20

February 10, 2020

Division of Medicaid, Office of the Governor
Office of Policy, Walter Sillers Building Suite 1000
550 High Street
Jackson, Mississippi 39201

Submitted via Email: Margaret.Wilson@medicaid.ms.gov
RE: Written Comments for State Plan Amendment (SPA) 20-0001 Durable Medical Equipment (DME) and Medical Supply Reimbursement

Dear Margaret Wilson,

AAHomecare is the national association representing durable medical equipment (DME) providers and manufacturers across the United States. Our membership consists of approximately 70% of DME providers, including large national and small local providers in all states throughout the country. I would like to take this opportunity to discuss the proposed rate reductions contained within this proposed SPA.

Over the past few years, our industry has been decimated by the Centers for Medicare and Medicaid Services (CMS) Competitive Bidding Program (CB), which resulted in drastic rate cuts in some cases as much as 65%. CMS now readily admits that CB is unsustainable and has suspended and overhauled the program. Unfortunately, it won't be re-launched until 2021. As a result of this program and the wide adoption of these rates we have seen close to 40% fewer DME providers throughout the country. According to the Dobson Davanzo Cost Study (attached); Medicare reimbursement only covers on average 88% of overall provider costs. Furthermore, the Dobson Davanzo Access Study (attached) exemplifies case managers observing Medicare reimbursement rates have complicated the discharge process and that delays in obtaining DME have often resulted in or contributed to Medicare beneficiaries' need for emergency care or hospital re-admission. These access to care issues have also caught the attention of Congress, the Protecting HOME Access Act (HR 2771) has been introduced to address the Medicare fee schedule and correct some of these issues. Access to DME has become problematic for far too many – especially in rural areas.

Specific protections are needed to safeguard beneficiary access to providers both in fee-for-service and managed care programs. The proposed rate reductions are problematic as many providers will no longer be able to provide these products to Mississippi Medicaid beneficiaries. The proposed rate reductions are severe and if providers do continue providing these products, they will be forced to offer extremely low-quality products with limited service. Often, these low-end products increase patient complications and result in emergency room visits, hospitalizations, long-term care facility stays, and other more costly treatments. Keeping patients healthy in the home is the most cost-efficient place of treatment. These proposed rate reductions may result in some immediate short-term savings within the DME benefit, but the overall impact to the state will be negative as indirect costs will skyrocket.

We urge the Division of Medicaid to reconsider these rate reductions and take into account the costs associated with limiting access to quality products that enable patients to receive treatment in their homes as opposed to more costly settings.

AAHomecare and our members desire to collaborate with your department to determine optimal solutions for everyone involved. I can be reached at DavidC@aahomecare.org or 202-372-0757.

Cordially,
David Chandler

Director of Payer Relations
American Association for Homecare

Attachments:
Dobson Davanzo Cost Study
Dobson Davanzo Access Study

Analysis of the Cost of Providing Durable Medical Equipment to the Medicare Population

Measuring the Impact of Competitive Bidding

Study Highlights

Authors: Allen Dobson, Ph.D., Steven Heath, M.P.A., Kennan Murray, M.P.H., Dylan Kilby, Joan E. DaVanzo, Ph.D., M.S.W.
Contact: Steven Heath, steven.heath@dobsondavanzo.com; 703-260-1763

About the Study

The Centers for Medicare and Medicaid Services (CMS) established a competitive bidding (CB) program in 2003 for Medicare Part B durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The purpose of the program is to facilitate the setting of prices through allotting contracts for the rights to supply DMEPOS to Medicare beneficiaries within competitive bid areas (CBA). It was anticipated that CB could save Medicare money if successfully and properly implemented.

In practice, the CB program has been controversial. Detractors argue that the CB process by design produces payments that lack transparency and do not support providers' acquisition, service, and distribution costs,[1,2] often resulting in reduced efficiency.[3] If so, large segments of the industry are financially vulnerable, as are Medicare beneficiaries. However, at this point in time, CMS contends that the CB process meets it objectives.

This paper presents an analysis of the costs incurred by providers of DMEPOS in providing equipment and associated services to the Medicare beneficiary population as gathered through a survey effort. It further compares these costs to current payments under the CB program as calculated using the weighted average Medicare reimbursement per unit. The study was commissioned by the American Association for Homecare (AAHomecare) in order to inform policy makers of the financial consequences of the CB process to the Medicare DMEPOS provider community and ultimately, to the Medicare beneficiary. The results of the study indicate that Medicare payments under CB do not cover providers' costs and may threaten beneficiary access and service quality, particularly in rural areas.

Competitive Bidding

The CB process requires DMEPOS providers to submit bids for selected products from specific product categories. The criteria for winning a bid are price, meeting the applicable quality standards, and meeting organizational financial standards. Winning providers who accept contracts from CMS are required to accept all requests from Medicare beneficiaries for bid items and are reimbursed at the price determined by the auction. The price is derived from the median of all winning bids for an item in a CBA.[4]

Importantly, bidders are not aware of the prices bid by others. Since the auction is non-transparent with an "essentially arbitrary set of vendors," the resultant price is non-competitively determined from a marketplace perspective.[5] The literature on CB, as summarized in our full report, suggests that the process contains design flaws, some of which have encouraged bidders to submit low bids that can lead to reimbursement levels which do not cover actual costs. The theoretical research contends that CMS' use of the median-pricing auction with nonbinding bids may not be the most efficient or effective methodology for pricing DMEPOS.[6] According to a recently published study, the median pricing system is "likely [to] result in supply shortages, diminished quality and service to Medicare beneficiaries, and an increase in long-term total cost."[7] Thus, there is extensive controversy surrounding the CB process and its ultimate effect on both providers and Medicare beneficiaries. This study seeks to obtain and provide information on the extent to which CB has led to reimbursement levels that are below providers' cost.

Methodology

In order to determine the cost of providing DMEPOS to Medicare beneficiaries, our analytic methodology comprised four steps: 1) creation of a technical advisory panel (TAP) to assist in the design of the cost survey; 2) development of the cost survey instrument to capture the costs of supplying DMEPOS; 3) administration of the cost survey with ongoing technical assistance to respondents; and 4) analysis of the costs of providing DMEPOS to Medicare beneficiaries as gathered from the survey in comparison to Medicare reimbursement.

The relationship between product cost and this average reimbursement, or the percent of costs covered, is the focus of our analysis. The total cost of providing a given product was

[1] Cramton, P. et al. "Letter from 167 Concerned Auction Experts on Medicare Competitive Bidding Program." Received by Pete Stark, 26 Sept. 2010. Retrieved from http://www.cramton.umd.edu/papers2010-2014/comments-of-concerned-auction-experts-on-medicare-bidding.pdf
[2] Cramton, P. et al. "Letter from 244 Concerned Auction Experts on Medicare Competitive Bidding Program." Received by Barack Obama, 17 June 2011. Retrieved from http://www.cramton.umd.edu/papers2010-2014/further-comments-of-concerned-auction-experts-on-medicare-bidding.pdf
[3] Cramton, P., Ellermeyer, S., and Katzman, B. (2015). "Designed to Fail: The Medicare Auction for Durable Medical Equipment." *Economic Inquiry*, *53*(1), 469-485.
[4] Centers for Medicare and Medicaid Services. (2012). Overview of the DMEPOS Competitive Bidding Program. Retrieved from http://www.dmecompetitivebid.com/palmetto/cbic.nsf/vMasterDID/79NTSG0132
[5] Tozzi, J. and Levinson, B. (2012). The Need for a Clinical Trial of CMS' Competitive Bidding Program for Durable Medical Equipment. The Center for Regulatory Effectiveness. Washington, DC.
[6] Cramton, P., Ellermeyer, S., and Katzman, B. (2015). "Designed to Fail: The Medicare Auction for Durable Medical Equipment." *Economic Inquiry*, *53*(1), 469-485.
[7] Ibid.

calculated as the sum of 1) the cost of goods, 2) the indirect costs allocated to the product category, and 3) the direct costs allocated to the product category.

Study Findings

1. The survey was distributed via Survey Monkey and made available on the AAHomecare website. The distribution list included, but was not limited to, members of AAHomecare. Completed surveys were obtained from 27 respondents. Survey respondents represent 12.7% of the Medicare expenditures for the HCPCS surveyed.
2. We believe that the survey results are generally representative of industry costs. If anything, firms that were able to complete the survey are highly sophisticated in cost accounting and are, therefore, likely to a have lower cost structure than the industry as a whole.
3. On average, all DMEPOS HCPCS included in the survey were reimbursed at 88% of overall cost, which is considerably below costs. The median percent of costs covered for each DMEPOS product category under study is presented below.

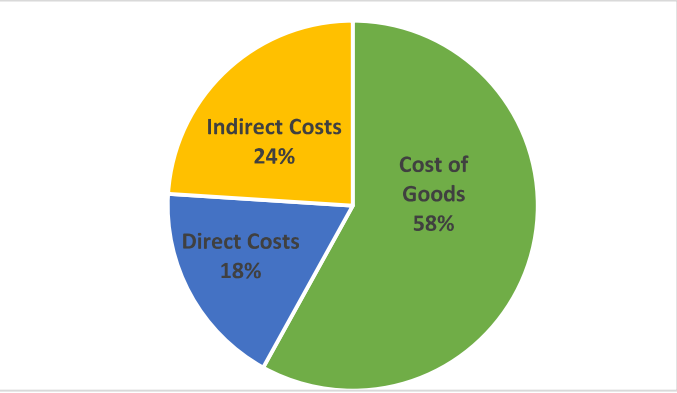
Exhibit ES-1: Percent of Costs Covered by Medicare

DMEPOS Product	Median Percent of Costs Covered
Standard Beds	69.58%
Heavy Duty Beds	90.35%
Liquid Oxygen	86.91%
All Other Oxygen	94.60%
BiPAP with Supplies	91.52%
CPAP with Supplies	67.83%
Walkers	83.88%
Lightweight Wheelchairs with Elevating Leg Rests	82.72%
Lightweight Wheelchairs with Footrests	82.79%
Standard Wheelchairs with Elevating Leg Rests	80.55%
Standard Wheelchairs with Footrests	71.35%
All Products Overall	87.68%

Source: Dobson | Davanzo DMEPOS Cost Survey

4. Of interest is the consistency of findings across providers, regardless of size, and across DMEPOS products (not shown in ES-1), in that the resultant payment-to-cost ratios calculated are typically well below 100 percent. This suggests that respondents who were able to complete the survey did so in a consistent fashion with highly consistent results.
5. The cost of goods alone, while important, does not comprise the overall cost of providing care. As shown in Exhibit 2, the cost of goods accounts for just over half of the overall cost of providing DMEPOS to Medicare beneficiaries. For the bona fide bid process, providers are only asked to provide an invoice showing that they can purchase the product at a cost below the bid price.[8] Other operational costs, which account for 42 percent of overall costs, are not evaluated in the bid process.
   - CB prices must cover all costs, not just the cost of goods.
   - Products must be delivered and consumers educated in their use.
   - These activities require corporate infrastructure and significant labor input.
   - Eventually, competitive bids that only cover the cost of goods are incomplete indicators of CB's adequacy.

Exhibit ES-2: Breakdown of the Cost of Providing DMEPOS to Medicare Beneficiaries



Source: Dobson | Davanzo DMEPOS Cost Survey

6. Our survey results do not reflect consistent scale; both large and small providers show relatively low payment-to-cost ratios.
7. Quality of service in rural areas is particularly threatened as there appears to be little opportunity to cover inadequate payments. This is because rural areas do not have the population density to win exclusive contracts, or make up for the revenue cost differential through volume. Anecdotal evidence suggests that even large companies are limiting services to rural areas by closing rural locations, limiting service areas, and/or offering fewer deliveries per month.
8. Our data suggest that there is very little room to cost-shift since public payers (Medicare and Medicaid) represent 45 percent of industry revenues and Medicaid payments have begun to fall in line with CB reimbursement. The omnibus bill passed in late December of last year (PL 114-113) contained a provision that will limit the federal portion of Medicaid reimbursement for CB items to CB prices starting January 1, 2019. While this does not require states to lower the overall reimbursement rate for DMEPOS, the state would be responsible for making up the payment difference. Additionally, in the private sector, many commercial and Medicare Advantage payers are reimbursing at or below Medicare CB payment rates, and TRICARE follows the discount Medicare fee schedule. This means that providers of DMEPOS have little opportunity to cost-shift and recover revenue lost from public payers.
9. The consistency of our findings indicates that the current CB process is financially unsustainable.
10. The CB process is fundamentally flawed in that CMS is currently paying the industry far less than the total costs incurred in providing DMEPOS goods and services to Medicare beneficiaries.

[8] 72 Fed. Reg. 18047, Tuesday, April 10, 2007.

11. The CB process does not seem to produce competitive market prices for goods or services.
12. The literature, as summarized in our full report, indicates that this may be due to the way the CB process is designed.
13. Given the design of the current CB system, there is no reason to assume that the process is sustainable in the long run for a large part of the industry. If Congress and/or CMS wish to see a sustainable industry, the public policy process may need to reconcile key aspects of CB as recommended in the Cramton report.[9]

Conclusion

The CB process has been controversial in its implementation, with detractors arguing that, by design, reimbursement resulting from CB does not cover providers' costs. The results of this survey demonstrate that CB is likely to be endangering the stability of the DMEPOS 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 DMEPOS. These findings are consistent across the providers who completed the survey.

Two key areas which demonstrate problems with the construction of the CB bid process are that:

- The bidding process is non-transparent and does not encourage bidders to include all costs in their bids. These factors lead to the reimbursement failures seen in the survey.
- CMS only considers the cost of goods when ensuring that no contracts are awarded below cost. CMS does not take into account all of the other costs that go into supplying DMEPOS to Medicare beneficiaries. This is insufficient to ensure that providers are not bidding in ways that are harmful to the stability of the market.

The CB process produces an auction that is not designed to reveal actual prices, and payments therefore drop below costs. There are three options that providers can take when payments are lower than costs: (1) make gains in efficiency; (2) implement cuts (which harms quality); or (3) go out of business. This survey shows that gains in efficiency have not yet reduced costs to bid prices.[10] Additionally, size does not matter, and big companies cannot successfully supply DMEPOS to all Medicare beneficiaries, especially in rural areas. Our study indicates that while large firms sometimes show more favorable payment to cost ratios, this is not true across all product categories. Few product categories thus far have allowed for costs to be recovered through volume. Additionally, there is little opportunity for DMEPOS providers to shift costs from Medicare to other payers.

The fact that, under CB, the median cost coverage under Medicare is often substantially below break-even is highly problematic for the DMEPOS industry and for Medicare beneficiaries. These low reimbursement rates may ultimately force some providers out of business. Other providers will have to raise prices or downsize operations, leading to a decrease in access to and quality of care for all patients. Overall, the CB program has the potential to significantly impact beneficiary access to needed equipment and harm the DMEPOS industry as a whole. Congress and CMS should consider changes to the CB process in order to have a stable and sustainable DMEPOS system.

[9] Cramton, P., Ellermeyer, S., and Katzman, B. (2015). "Designed to Fail: The Medicare Auction for Durable Medical Equipment." *Economic Inquiry*, *53*(1), 469-485.
[10] Hayford, T., Nelson, L. & Diorio, A. (2016). Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios (Working Paper Series 2016-04). Washington, DC: Congressional Budget Office.

Summary of Report Findings: Analysis on the Impact of Competitive Bidding on Medicare Beneficiary Access to Durable Medical Equipment

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorized the Centers for Medicare and Medicaid Services (CMS) to establish a competitive bidding (CB) program for Medicare Part B durable medical equipment, prosthetics, orthotics, and supplies (DME). The stated goals of the CB program for DME are to:

- assure Medicare beneficiaries access to quality DME products and services;
- reduce the amount Medicare pays for DME under a payment structure that is reflective of a competitive market;
- limit the financial burden on beneficiaries by reducing out-of-pocket expenses, and;
- contract with providers that conduct business in a manner that is beneficial for the program and its beneficiaries.[1]

CB has been interpreted as fulfilling this requirement for a market-based solution; however, the program is highly controversial. This study concludes that the CB process appears to have numerous unintended consequences.

Survey

Dobson | DaVanzo conducted a survey of beneficiaries, case managers, and suppliers of DME to analyze the effects of the CB program.[2] Through the survey, respondents provided input via fixed "yes or no" response questions and added nuance and depth via free-text comments. It was disseminated via email and social media channels, with a telephone option available to those who preferred to share their feedback in person.

As a primarily electronic survey, numerous responses were received quickly from a diverse range of stakeholders. Internet-based surveys are an effective method of obtaining qualitative and quantitative data in health services research, and are "more rapid and cost efficient than other interview modes" within epidemiologic studies in a geographically varied population.[3] Furthermore, crowdsourcing via social media is "an efficient and appropriate alternative to standard research methods" compared to traditional participant pools.[4]

Results

There were 1,064 respondents to the survey. Of these 437 were beneficiaries, 361 were case managers/discharge planners, and 266 were DME suppliers. Respondents are generally representative of various geographical (e.g. urban bid, and urban non-bid, rural) and demographic profiles compared to CMS data. Due to the volume of responses received in each of the three categories, our high-level results are statistically significant at the 0.05 level.

Key findings are as follows:

- Beneficiaries and case managers are experiencing a wide range of quality and access issues, and many suppliers are strained to the point where beneficiaries question their capability to meet their needs.
    - 52.1% beneficiaries report problems accessing DME and/or services
    - 88.9% of case managers report an inability to obtain DME and/or services in a timely fashion
- Beneficiaries and case managers reported difficulties in locating suppliers to provide DME and services, resulting in unnecessary medical complications and expenses. This was

[1] Centers for Medicare and Medicaid Services. (2007). 42 CFR Parts 411 and 424 | Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues; Final Rule. (Federal Register, Vol. 72, No. 68). Washington, DC.

[2] Dobson | DaVanzo was commissioned by the American Association for Homecare (AAHomecare) to conduct the survey.

[3] Rankin, M. et al. "Comparing the reliability of responses to telephone-administered vs. self-administered web-based surveys in a case-control study of adult malignant brain cancer." *Cancer Epidemiol Biomarkers Prev.*, 17, no. 10 (2008): 2639-2646. doi: 10.1158/1055-9965.EPI-08-0304

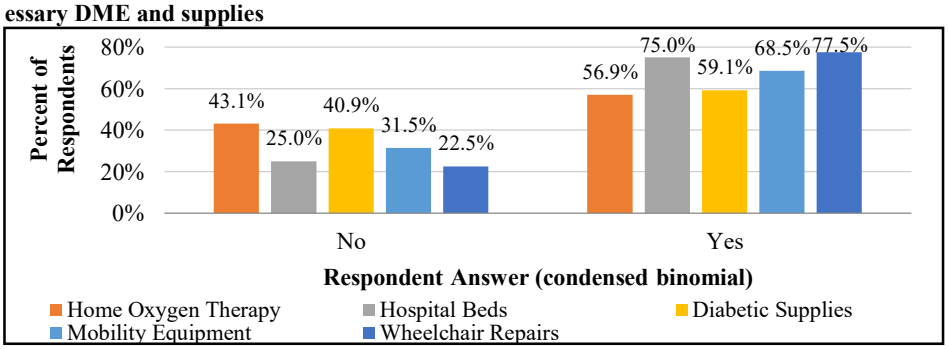
[4] Behrend, T., Sharek, D., Meade, A., and Wiebe, E. "The viability of crowdsourcing for survey research." *Behav Res.*, no. 43 (2011): 800-813. doi: 10.3758/s13428-011-0081-0

reported to be especially troubling for beneficiaries who receive oxygen therapy with 74.3% reporting some sort of disruption to their service.

- Beneficiaries are experiencing anxiety over their ability to get needed DME and at times are choosing to leave the Medicare market and pay for their equipment privately out-of-pocket in order to avoid delays, receive better quality items than those supplied by recipients of a CB contract, and exercise their choice of supplier.
    - 36.9% of patients reporting an increase in out-of-pocket expenses related to their DME.
- Case managers noted that the program has complicated the discharge process and that delays in obtaining DME have often resulted in or contributed to Medicare beneficiaries' need for emergency care or a hospital re-admission.
    - 70.8% of case managers report discharge delays of 1-7 days
    - 61.7% of case managers say patients are having medical complications some of which result in readmission to the hospital
- Most suppliers (65%) report having to reduce the number of items supplied or are fearing for their company's viability due to unsustainable payment rates. Smaller firms noted that they face significant pressure that may force them to close or be acquired.
- These problems are particularly prominent in rural areas. Rural beneficiaries noted significant increases in stress and anxiety due to decreased frequency of deliveries on non-route days; they increasingly felt as if they had to demonstrate more of a "need" to receive medically necessary items.

Figure ES-1 below shows that beneficiaries reported access issues in obtaining DME which is indicative of the broader sentiment of the results.

Figure ES-1: Binomial frequency of beneficiary self-reported experience of access issues in obtaining medically necessary DME and supplies



Implications

Our findings indicate that the CB program has 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 suppliers to deliver quality products without delay. While transitions are by their nature disruptive, the degree to which survey respondents identified negative impacts with CB suggests that the program is in need of mid-course corrections. If timely adjustments are not made, there is little doubt that beneficiaries, case managers, and suppliers will continue to face adverse outcomes, particularly in rural areas.

Hello,

I've read the public comments on the website and want to express my input as a pediatrician who works with complex care patients.
I imagine that there are many of our children across the state who are in the home and community settings. It is our daily mission to gather the supplies that the parents need As part of this care.
Our DME companies are critical to that mission.
Certainly we all need to be cost efficient, but we ask the Division to ensure that we do not force these companies out of business. One of the letters in public comment came from our long time nurse educator at Children's Hospital.
For instance, under-reimbursement of such items as gastrostomy tube buttons and tubing is counter productive as it forces the surgery clinics to bring the children in quarterly instead of annually.
Thank you for your attention to these issues.
Sara Weisenberger MD
Jackson MS

02/26/20

Children's Healthcare of Mississippi
University of Mississippi Medical Center

2/21/2020

Margaret Wilson
Division of Medicaid
Office of the Governor, Office of Policy
Walter Sillers Building, Suite 1000
550 High Street
Jackson, Mississippi 39201

RE: Proposed DME fee schedule

Dear Ms. Wilson:

As a surgeon involved in the care of vulnerable children with tracheostomies, I was very concerned with the proposed cuts in reimbursement for vital equipment including tracheostomy tubes. Children with a tracheostomy breathe through these small tubes, which have a very limited life and typically cannot be re-sterilized.

I am speaking specifically to pediatric tracheostomy patients, of which I have a deep understanding. These are very complicated children who require a great deal of care. They are extremely vulnerable. Their parents frequently cannot work because of the care they have to provide the sick child. Not having access to new tracheostomy tubes will cost lives.

I urge the Division to consider the consequences of these cuts to the reimbursement for tracheostomy tubes, which would appear to be a relatively small savings compared to the overall health care costs for such a child. These are the sickest and most vulnerable citizens. They should not be left behind.

Sincerely,

Jeffrey D. Carron, MD, FAAP, FACS
Professor, Department of Otolaryngology and Communicative Sciences
Pediatric Otolaryngology
Director, Pediatric Cochlear Implant Program
Children's Healthcare of Mississippi
T: 601-984-5456 F:601-815-3062
www.umhc.com

Avritt Medical Equipment, Inc.

4020 Hwy 8 East, Cleveland, MS 38732-8551 * 662-843-7007

February 24, 2020

Dear Mrs. Wilson,

I am writing as part of the public comments on the proposed fee schedule reductions for Durable Medical Equipment and Supplies to be implemented on 03/01/2020.

These reductions are rather LARGE and are at or well below our cost. Surely we aren't expected just lay down and say; "Oh well, this is just the way it is now" and just accept these price reductions! Logic dictates that a company can't stay in business by taking losses. So we need to know is there going to be any efforts to fix these prices and make them more reasonable? If not we just cannot afford to provide these items to our Medicaid patients any longer. I am sure we are not the only provider that feels this way.

If these changes in pricing do take place Medicaid beneficiaries will not be getting the quality care and services that all people deserve. Without DME providing these services many beneficiaries would have to go to hospitals or other skilled nursing facilities. This would actually defeat the purpose of these proposed cuts and reductions. The very existence of DME companies actually help the Medicaid Budget by helping patients have better healthcare at home instead of having to go to the hospital as often.

Sincerely,

Memrie Keith

Billing Dept

To whom it may concern:

After reviewing the State Plan Amendment (SPA) 20-0001, I have listed some of our concerns below:

1. VIII. Durable Medical Equipment paragraph B. IF there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid or through manual pricing. The DOM will utilize the lower of the DOM's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. The fees will be updated as determined by the DOM. *how do providers know on those items what we will be paid and which method will be used and who do we contact to find out when attempting to provide such item *
2. Medical Supplies: paragraph B. Same Question as above.
3. Decreasing the amount of reimbursement for the incontinent codes will cause some providers to stop servicing patients for these items. We have always been able to find good quality products to dispense to our patients at the current fee scheduled amounts. Providers will be forced to look for products with less quality (cheaper) and may lose business over sub standard products. Not all incontinence products hold up to allow for the amount issued on a monthly basis. Some families of incontinent patients will be forced to purchase out of pocket to make up when "cheaper" products don't last or hold up as long (such as Leakage issues requiring more frequent changes).
4. I have also recently seen that 3 items: A7520, A7521, and B4088 have been removed from the upcoming SPA changes, but will be items that DOM can take more time to review. These items should NEVER be given a set fee schedule. The range in price is far too large for a median price to accommodate. Some cost providers more than double the proposed amounts listed in this SPA. Please consider leaving them as manually priced. If this fee changes, we currently have 4 patients that we will not be able to service beyond the change and would likely stop servicing patients for all trach needs as it would be below our cost.

Thrift Home Care has two locations. McComb 00440851, Brookhaven 00440850

Thank you for your time and consideration,

Sylvia King
General Manager
Thrift Home Care
119 W. Presley Blvd., Ste. C
McComb, MS 39648
Phone: (601) 684-2871
Fax: (601) 684-4146