ISSUE BRIEF

Indiana FSSA Must Allow Time for Needed Analysis of Proposed Medicaid Payment Changes for Home Medical Equipment and Supplies To Avoid Access Problems for Medicaid Recipients

September 3, 2020

Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP), is proposing changes to the payment policies for home medical equipment (HME) and medical supplies. On August 12, FSSA published the "*Notice of Changes in Methods and Standards for Medicaid Payments for Medical Equipment and Medical Supplies"* in the Indiana Register with public comments accepted until September 11, 2020.

OMPP is intending to revise the Medicaid payment rate for HME and medical supplies subject to the requirements of the 21st Century Cures Act of 2016 to the lowest non-zero Indiana Medicare fee schedule rate or competitive bidding single payment amount effective 2/01/21. OMPP has indicated that this is to comply with the federal law and CMS requirements set forth in State Medicaid Director letter 18-001. They estimate that the fiscal impact of these changes will be a decrease in state and federal expenditures of approximately $1.96 million for federal FY 2021 (federal share of $1.29 million, state share of $0.67 million) and $2.95 million for federal FY 2022 (federal share of $1.94 million, state share of $1.01 million).

According to OMPP, the objectives for the rate setting initiatives are to provide sustainability, alignment, transparency, and were developed with input from a variety of stakeholders. This Issue Brief outlines the HME and complex rehab technology (CRT) community's concerns with those objectives and the need for further analysis and changes:

Sustainability - HME stakeholders are committed to a strong partnership with all payers including state Medicaid agencies who have significant budget challenges, especially during the public health emergency (PHE) caused by COVID-19. As we've demonstrated over the past few years, we are willing to roll up our sleeves, evaluate reimbursement and policy, and make careful, necessary decisions to ensure sustainability of the Medicaid program. We appreciate the long-standing relationship and open line of communication to meet quarterly to review policy and claims adjudication issues collaboratively with FSSA and the managed care organizations. Unfortunately, we missed an opportunity to use that forum for a constructive, comprehensive dialogue that is needed to work through proposed program changes which require thorough assessment. Today's proposed changes and the timeframe of their adoption are far too aggressive and go beyond Cures Act requirements. The timing is especially problematic during the pandemic. HME providers have drastically increased product and operational costs, staffing challenges and medical supply chain disruption that will likely continue for some time.

Medicare Alignment - Medicare rate alignment for the Medicaid patient population is problematic. Using the LOWEST Medicare rate of the three Indiana Medicare rates available, is disastrous. Medicaid and Medicare are fundamentally different programs serving distinct populations with vastly different healthcare needs. Furthermore, the Medicare rates are based on the flawed "competitive bidding" program which produced unsustainable payment levels; and at the urging of Congress, was temporarily paused in November 2018 and remains fluid today. Additionally, Medicare established different rates for non-CBA areas and rural areas because CMS and Congress recognized these rates can limit access to care. When inquiring about Indiana's access monitoring review plan, OMPP responded that CMS has a "long-standing policy" that using Medicare rates is sufficient to ensure access to Medicaid patients. This position fails to recognize Medicare has multiple

rates in place to ensure access and the "long-standing policy" says nothing about adopting the lowest Medicare rate. We support developing a framework that will support an adequate rate-setting methodology but emphasize OMPP must recognize the unique needs of the Medicaid population, and product acquisition and staffing challenges during the PHE, to safely support patients at home and ensure access to care. The following are some examples of rate reductions that will likely cause access issues:

CPAP/BiPAP	62% reduction	Negative pressure wound therapy	62% reduction
CPAP supplies	46% reduction	Oxygen concentrator	70% reduction
Hospital beds	53% reduction	Manual wheelchairs	34% reduction

Access to Care - HME providers play a critical role in preventing hospitalization and care in other acute care settings. They were uniquely valuable with hospital census surges during the COVID-19 pandemic which has not ended and many are predicting a rise of patients requiring hospitalization in the coming months as traditional flu and rising COVID-19 numbers combine. Our members help reduce extraordinary burdens on hospitals and the entire healthcare system. Furthermore, the HME provider network is already compromised. Over the past decade, we have seen a 29% decrease in the number of Indiana HME providers largely as a result of the Medicare competitive bidding program. Making drastic payment cuts to HME providers during a public health emergency that risks access to quality homecare is not in the best interest of Medicaid consumers nor the State's budget.

Compliance with 21st Century Cures Act – According to OMPP, the changes proposed today are being made to comply with the Cures Act which prohibits federal Medicaid reimbursement to states for certain HME expenditures that are, in aggregate in excess of what Medicare, would have paid. After the law passed several years ago, Great Lakes and the American Association for Homecare met with FSSA on 12/21/17 to discuss the Cures Act, CMS guidance specific to HME requirements and to request State data to assess and analyze what adjustments may be needed to meet the aggregate spend. CMS' direction included several key points:

- Limits the federal contribution for DMEPOS for 255 select E, K, and A codes
- Aggregate spend analysis should include Medicare rates in non-CBAs and rural areas, not just lowest Medicare rate
- States can still set their own payment rates to ensure access to care
- Cures Act only affects primary fee for service claims, not MCOs, not secondary claims
- Law affects aggregate expenditure for HCPCS code listing only

Timeframe and review process – While we appreciate FSSA's willingness to meet in recent months, the scope and severity of the changes is disproportionate to the amount of time we're devoting to this work. We respect the agency has many healthcare sectors to administer but these are massive changes for HME and CRT which includes hundreds of codes with complex coverage policy, medical documentation requirements and processes. This requires careful review to understand the proposals and offer solutions or adjustments to balance the concerns of providers, the needs of patients and the budget limitations of the State. No further discussion occurred after the December 2017 meeting related to the Cures Act, not even at regular quarterly meetings, until *ICHP bulletin BR201936* was published 9-03-19 with less than 30-day notice for implementation. The HME/CRT community reacted with strong concerns and we appreciate that the published changes were paused. However, after one in-person meeting and four follow-up calls, we are faced once again with many of the same changes from a year ago including the adoption of the lowest non-zero Indiana Medicare rate or competitive bidding single payment amount with a number of details yet to be clarified during an unprecedented public health emergency.

Our "Ask" - We respectfully request that the submission of the proposed State Plan Amendment to CMS (for phase 1) be delayed until 10/01/20 to allow needed further analysis and discussion. This brief delay is critical to avoid unintended consequences caused by the rushed implementation which could lead to access issues for patients, harming HME providers and risk increased spending for the State. We urge OMPP to continue working with the HME and CRT providers, recognizing the challenges of the current public health emergency and the critical role of HME providers in the fight against the pandemic. Additionally, given many pending issues with Medicare rates and their correlation to Medicaid reimbursement, there are currently numerous issues in flux. We stand ready to partner with the State but ask for a slight delay to allow careful consideration of our concerns and questions and to continue this important discussion together.