

OAMES Testimony

Proposed ODJFS Rules 5101:3-10-21 and 5101:3-10-03
Incontinence Supplies, Medicaid supply list and appendices

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My name is Kam Yuricich and I am here today representing the Ohio Association of Medical Equipment Services. OAMES is comprised of approximately 170 home medical equipment providers, manufacturers and service organizations serving patients in communities throughout Ohio. Thank you for the opportunity to testify. I am here to oppose changes proposed to rules 5101:3-10-03 and 5101:3-10-21 based on the following reasons:

1) Selective contracting is not a legislative mandate as stated by the Department.

ODJFS has stated they are “mandated by the legislature to pursue selective contracting”, referred to as “value purchasing” in these rules. This is not accurate and makes an inappropriate leap of authority based on a report issued by the Ohio Commission to Reform Medicaid in 2005. “Legislative mandates” are often referred to as “laws;” and this report was never adopted into law by the General Assembly. Furthermore, the document contains literally hundreds of recommendations – DME “value purchasing” being only one. As an example, the report also recommends the implementation of care management programs that have not been accomplished. OAMES would argue that a bidding program for home medical products would be a roadblock to any care management initiative. By its restrictive nature, “value purchasing” creates inefficiencies and breakdowns in the continuity of care and the myriad of health care professionals serving Medicaid consumers. ODJFS should not assume that this report grants them legislative authority held only by the Ohio General Assembly, and given the conflicting nature of some of the recommendations, it is not surprising that the legislature has NOT adopted this report wholesale.

2) The rules offer insufficient detail to assure the public interest is being met.

ODJFS offers no procedural detail or description of the program’s framework in these rules. The incontinence supply rule is ambiguous, there are no specifics as to how the bidding process will be done, what bid selection criteria will be used, how products will be assigned to Appendix B and other important factors to understand the basic design of this program. When these details have been requested by stakeholders, ODJFS has replied that they’ll be contained in the Request for Proposal and are not available at this time. By contrast, CMS’s rule for its Medicare competitive bidding program was over 400 pages. A program of this magnitude simply cannot be implemented without public scrutiny into its procedures and processes, and the Department has an obligation to ensure these details are publicly available.

3) Selective contracting is not a “magic bullet” to fix our health care challenges.

Take Medicare’s own competitive bidding program, for example. This program failed when recently implemented on July 1st. By way of background, in the Medicare Modernization of Act of 2003, Congress mandated this controversial DME competitive bidding initiative. It was halted by an overwhelming veto-proof margin of Congress just two weeks after launching due to significant problems when implemented. Ironically, the day the U.S. House of Representatives voted to stop Medicare competitive bidding, the Ohio Department of Job & Family Services filed rules to proceed with “value purchasing”, its Medicaid competitive bidding program. Almost the entire Ohio Congressional delegation, including both Senators Sherrod Brown and George Voinovich as well as 16 of the 18 House Members, voted in strong bi-partisan fashion to suspend the Medicare initiative due to the impact on two Ohio cities affected by the July 1 roll out.

ODJFS has frequently pointed to the Medicare program as one of the motives for implementing selective contracting in Ohio. They’ve reported that “Ohio received an affirmative response to its selective contracting Request for Proposal (RFP) for incontinence garments from CMS on November 2, 2007.” In light of CMS’s own failure to launch its program successfully, having the federal agency’s approval offers no reassurance that Ohio should move forward. In fact, for Ohio Medicaid to proceed with these rules and implement a contracting program when CMS’s national model was just halted by Congress is irresponsible and completely unfair to our state’s Medicaid beneficiaries.

While today’s proposed rule change only affects incontinence supplies, we expect ODJFS will proceed with other medical products as indicated by the blanket selective contracting rule earlier this year. Thus, we wholeheartedly believe that the careful coordination of a patient’s care by HME providers today will unravel as more products are subject to competitive bidding and more providers are eliminated by “value purchasing.”

Furthermore, according to a report by the National Conference of State Legislatures titled “*Medicaid Cost Containment: A Legislator's Tool Kit*” (March 2002) listing various cost cutting strategies for Medicaid programs, one of the arguments against selecting contracting is the “lack of participation and true competition in the bidding process that may lead to an inadequate supply of providers or lower overall quality of care” for recipients. The report further states: “awarding contracts to different providers over time may lead to discontinuity of care.” In fact, the report lists fewer “pros” than “cons” when considering this new payment model and may explain why only six states currently utilize some form of DME selective contracting (three for oxygen, three for incontinent supplies). Additionally, we have learned that Medicaid programs in Pennsylvania and Idaho – and Minnesota as recently as May – have abandoned efforts to implement selective contracting for various home medical products. Clearly, with Congress stopping Medicare’s bidding program and very few states using this payment model, selective contracting is by no means a sure-bet or step forward in reforming Medicaid’s DME program.

4) Cost vs. Value - Understanding Real Reform

ODJFS and OAMES’ discussions during rule reviews have centered largely on reimbursement. While payment is important, it only addresses the department’s bottom line and does not take Medicaid consumer’s needs into account. What needs to be considered is the value of what’s being “bought.” If Medicaid DME expenditures must be reduced due to budget constraints and

growing enrollment, OAMES would suggest a careful examination of all rules dictating the delivery of each product. This would include analyzing the costs associated with those rules, the products themselves and make reform on both sides of the equation – the reimbursement of the product and service AND the state and federal rules that dictate their coverage. This would ensure any reform is fair to the consumers and families receiving Medicaid benefits, the taxpayers funding this benefit, providers supplying the product and services, and all other segments of the health care field relying on this benefit being delivered.

Our experience shows that ODJFS' approach to reform is simply to make cuts rather than analyze what the State is paying for and make careful, informed decisions about any necessary changes that achieves the best possible health care outcomes for consumers. True reform can be achieved in an objective exercise between the industry and ODJFS without dismantling the HME community by auctioning selected health care services in a move that threatens Ohio jobs, disrupts continuity of care, and wipes out personal and professional relationships between patients and health care providers in their local communities.

If home-based DME services are reviewed in isolation to other Medicaid benefits, unintended consequences such as increases in medical transportation or emergency room visits or poorer health outcomes caused by decreasing patient compliance or delays in timely hospital discharges, are likely to occur. This is not "reform" but simply reducing costs in one benefit by shifting it to another. We call it the "silo effect" and it is a dangerous, short-sighted logic for developing public policy.

5) Short Term Gain vs. Long Term Loss - An Economic Reality

In February 2008, Dr. Brian O'Roark and Dr. Stephen Foreman, professors with Robert Morris University in Pittsburgh, released a study titled "*The Impact of Competitive Bidding on the Market for DME.*" This report concluded artificial limitations on supply of DME through a selective contracting program may lead to short-term program savings at the expense of future market power for suppliers. While this study focused on the Medicare program, the economic principles are universal. The study summarizes that today "DME is a competitive market both in theory and in practice. Artificial limits on supply will produce artificial shortages and access problems in the intermediate run (5-20 years), will ultimately increase price and reduce social welfare and will, more likely than not, result in monopoly profits for the successful bidders."

ODJFS has responded to concerns raised about the economic impact by stating that "schools of thought differ amongst economists." However, basic principles of supply-and-demand are not a subjective concept and we urge the Department to analyze carefully what long-term effects a contracting program would have on Ohio's economy. In fact, ODJFS goes on to say that the studies "were insufficiently persuasive to alter the start of the CMS' national selective contracting initiative." However, one need only point to the recent failure of the Medicare program to conclude that perhaps they should have considered the information in these studies more carefully before proceeding.

The home medical equipment community is overwhelmingly a network of small to medium-sized businesses serving relatively small service areas. CMS estimates that approximately 85 percent of registered HME providers are considered small businesses, according to the Small

Business Administration definition. In ODJFS's response to clearance comments on the small business and jobs issue, they state, "the impact on existing providers is expected to be significant." More alarming is the Department's response to testimony at the January hearing in which they agreed with an unnamed stakeholder who stated, "a single award is in the best interests of both the State and program beneficiaries." A government-created selective contracting scheme is the opposite of competition. Real competition with natural market pressures help to hold down prices; it gives consumers choice; and it keeps competitors accountable for the quality of their products and services. Bottom line: it gives the payer of products and services, in this case the Ohio Medicaid program, the best long-term value for their investment.

In conclusion, if the Department proceeds with this rule and the implementation of a selective contracting program, OAMES will prepare to testify at the August 25th JCARR hearing to make a case to invalidate the rule based on three of the four criteria under JCARR jurisdiction including legislative intent, conflict with another rule and incomplete fiscal analysis.

Ohio needs a healthy home and community-based health care market to care for our pediatric, disabled and aging populations. The recent rate increase to these providers under Governor Strickland's administration and the expansion of PASSPORT recognizes homecare's positive contribution to Ohioans in need. Stakeholders are working together on the Ohio Unified Long Term Care Budget as more Ohioans are being served in a community setting. OAMES remains willing to work with ODJFS to reach effective solutions for Medicaid reform. These solutions must identify efficiencies to reduce the State's acquisition costs for products and services in combination with modernizing burdensome processes at the State. We firmly believe a government-run contracting scheme is not in the best interest of the Medicaid program and its beneficiaries, the taxpayers, health care professionals, nor Ohio's small business community.