STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

June 15, 2018

Home Medical Equipment and Services Association of New England
515 Kempton Street
New Bedford, MA 02740
Attn: Karyn Estrella, CAE, President & CEO

Re: Response to HOMES DME Cures Act Alternative Fee Schedule Proposal

Dear Ms. Estrella,

I am writing in response to the May 1, 2018 proposal from the Home Medical Equipment and Services Association of New England (HOMES), submitted on behalf of its member medical equipment and related service providers. It is our understanding that the proposal was developed and submitted in collaboration with the American Association for Homecare (AAHomecare) and the National Coalition for Assistive and Rehab Technology (NCART). Specifically, this proposal presents one potential method for Connecticut's Medicaid Program to remain compliant with the federal Durable Medical Equipment (DME) Federal Financial Participation (FFP) Limit, established through 42 U.S.C. § 1396b(i)(27), as amended by section 5002 of the 21st Century Cures Act, Public Law No. 114-255, effective January 1, 2018. As you know, federal law limits a state's federal Medicaid matching funds (FFP) for specific DME to the maximum of what Medicare would have paid for the same items (incorporating Medicare's Competitive Bidding Program pricing).

To summarize the Department's response, described in detail below, we agree to:

- Reimburse for positive airway pressure (CPAP or BiPAP) supplies separately while the PAP unit is being rented;
- Implement two of your administrative and policy change recommendations; and
- Conduct a LEAN process to develop authorization process and other policy efficiencies with provider and industry representatives.

Before discussing the Department's response in more detail, on behalf of Commissioner Bremby and the Department, I wish to extend our gratitude for the time and effort that went into developing your proposal and for the spirit of collaboration in which the proposal was created. We especially appreciate your efforts to ensure that the needs and opinions of many MEDS vendors were considered and the collaborative spirit of the participants as evidenced by the ongoing dialogue with your associations and various providers, the in-person meetings, conference calls, and exchange of data and other correspondence.

Among the many items included in your proposal, there are several which the Department accepts and will implement as quickly as possible:

- Reimburse for positive airway pressure (CPAP or BiPAP) supplies separately while the PAP unit is being rented, effective prospectively, on or after August 1, 2018. Consistent with the spirit and intent of the federal DME FFP Limit, reimbursement for these PAP supplies will be reduced to the lower of: 100% of the Medicare fee schedule or the amounts that Medicare would have paid under its Competitive Bidding Program, or the current Medicaid fee schedule rate. Prior authorization requirements, which allow up to 3 months of rental for the device, will remain the same. A new prior authorization would be submitted for the purchase of the device and the DME provider must supply proof that the member is compliant with using the device.

- Implement two of the administrative and policy change recommendations included in your proposal. Specifically, effective July 1, 2018, consistent with section 17b-99 of the 2018 supplement to the Connecticut General Statutes, as amended by section 5 of Public Act 18-76, the Department intends to accept:
    - a facsimile image, an electronically maintained document or original pen and ink document as sufficient proof of a written order; a photocopy; and
    - a receipt signed by the recipient of medical assistance or a nursing facility representative or, in the case of delivery of a covered item or service by a shipping or delivery service, a supplier's detailed shipping invoice and the delivery service tracking information substantiating delivery as sufficient proof of delivery of a covered item or service.

  For both of these changes in required documentation, the Department expects that (i) the proof provided is sufficiently legible, (ii) the proof provided is not contradicted by other sources of information reviewed on audit, or (iii) the commissioner, or any entity with which the commissioner contracts to conduct such audit, makes a good faith determination that the provider is not engaging in vendor fraud.

The Department will issue a policy bulletin advising MEDS providers of these policy changes.

In addition, the Department is proposing continuing the dialog with industry representatives to investigate other administrative changes that would lead to shared efficiencies by conducting a LEAN process with industry representatives to review authorization processes. Several years ago the Department, with staff from Community Health Network of Connecticut (the Department's medical administrative services organization) and NCART representatives participated in an effort to develop the authorization process currently in use for complex rehabilitation technology. In our earlier meetings NCART leadership expressed their dissatisfaction with the current process so it appears to be a good time to collaboratively review this process. We envision a LEAN process that would include, but not be limited to, review of the CRT approval processes.

In regards to the remaining items proposed, the potential savings calculated by the Department through its analysis were significantly lower than the estimates presented. For example, the Department's federal financial participation (FFP or 'match') rate is considerably higher than 50% for some Medicaid coverage groups, and is not the uniform 50% rate assumed in your proposal.

Further, the proposal underestimates the savings to be achieved by reducing only the specified seven codes and does not forecast for increased utilization. While the proposal assumes utilization will remain static, utilization typically increases each year. As a result, the savings built into your proposal, which did not consider increases in utilization, is likely to erode quickly. Additionally, the increase in the number of procedure codes to the Competitive Bidding Program by CMS will increase the Department's liability. Following accepted reimbursement methods ensures a provider's ability to predict Medicaid revenue and the Department's compliance with next year's CMS demonstration.

The proposal included savings attributed to increasing the rental to purchase period to 13 months. The Department's analysis concluded that this proposal would be cost-neutral and only if the majority of these items are eventually purchased. In the case of BiPAP and CPAP machines, it is the Department's experience that only a small number of these items are used for greater than a month or two; therefore, extending our rental period from the current 3 months to 13 months would substantially increase costs.

Other items included in your proposal that the Department has not accepted would similarly expose the state to considerably higher costs. In particular, paying respiratory therapists as independent providers would require Connecticut, as a fee-for-service state, to reimburse all independent respiratory therapists separately in all contexts, not just those employed in your industry.

Lastly, the Department agrees that following an established reimbursement methodology whenever possible, in particular that of the Medicare Program, can help simplify coverage rules and claims submission procedures for both the industry and the Department. To shift some coverage rules to be consistent with Medicare, where appropriate and/or possible, while shifting other coverage rules away from Medicare's rules, would serve to add complexity, rather than ease it. In regards to oxygen, the Department will continue to follow Medicare's guidelines as specified under the Medicaid regulations for payment of oxygen.

In summary, for the many reasons listed above, the Department does not agree that reducing only the seven HCPCS codes listed in your proposal will ensure that our expenditures will remain below the federal cap for calendar year 2018. In the interest of minimizing the likelihood that the Department will need to make further substantial adjustments in the MEDS fee schedules, the policy and reimbursement methodology changes effective April 1, 2018 that were announced in PB 2018-18 will remain in effect. The only exception to this will be that the Department will be revising the two patient lift codes (E0639 and E0640) to be manually priced. Manual pricing will ensure that pricing for patient lifts takes into account actual costs associated with the purchase and installation of patient lift systems.

Again, thank you for your proposal. We greatly appreciate your input and suggestions proposed to support the Department's ability to comply with the federally required DME FFP Limit while maintaining beneficiary access. We appreciate the services available to our Medicaid members by DME providers throughout the state and we look forward to continuing our work together to meet the needs of our shared members.

If you have further questions, I may be reached by telephone at 860-424-5583 or by email at Robert.Zavoski@ct.gov.

Sincerely,

Robert W. Zavoski, M.D., M.P.H.
Medical Director
Division of Health Services

Cc: Laura Williard, AAHomecare
Donald Clayback, NCART
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Kathleen Brennan, Deputy Commissioner
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