

**TESTIMONY OF THE
NEW ENGLAND MEDICAL EQUIPMENT DEALERS ASSOCIATION
RELATIVE TO HOUSE BILL 1279 – AN ACT ESTABLISHING A COMMISSION TO
STUDY STATE MEDICAID REIMBURSEMENT
AUGUST 16, 2006**

Good morning Representatives Mason, McMahon and Donovan. My name is Karyn Estrella, Executive Director of the New England Medical Equipment Dealers Association (NEMED). We appreciate this opportunity to comment on House Bill 1279, an act establishing a commission to study State Medicaid reimbursement. NEMED is a regional trade association representing respiratory, rehab/assistive technology, durable medical equipment and home infusion therapy providers in the six New England states. Our members in New Hampshire provide products and services to approximately 85% of the Medicaid beneficiaries in the State.

NEMED is pleased to see that the State is considering the establishment of a committee to study Medicaid reimbursement and if this commission is indeed established, we would look forward to the opportunity to work with you.

Before we get into the discussion of reimbursement, we feel it is important for you to understand who we are. What is durable medical equipment? What products and services do we provide? Where do we fit into the healthcare continuum?

In the Industry Overview binder that you have been provided, you will see that the durable medical equipment (DME) industry encompasses a vast array of products and services. We deliver basic equipment such as canes, crutches, walkers and hospital beds. We deliver highly customized wheelchairs to children and adults like the chairs in your handout. We deliver oxygen therapy in the home as well as manage hi-tech pediatric and adult patients including ventilator management. We deliver infusion therapy in the home such as pain management and chemotherapy as well as Total Parenteral and Enteral Nutrition (tube feeding). And much more.

The DME industry was formed more than 40 years ago as a way to reduce the cost of healthcare. And we've done just that. However, our industry has evolved over the last four decades. Advancements in technology means that more and more patients who were once confined to hospitals and nursing homes to receive these products and services can now be taken care of in the home at a fraction of the cost.

The DME industry is the solution to the rising cost of healthcare. We should not be viewed as an "addition" to the healthcare delivery system. Not only are we the preferred setting for patients - we are the most cost-effective option. In three separate statements in 2005, CMS Administrator Mark McClellan stated:

“[Medicaid Home-and Community-Based Care] programs have shown that, often, the most cost-effective place to provide care is where most people prefer to receive their care: living in their homes, connected to their communities, surrounded by friends and family. And that

means better outcomes without higher costs in Medicaid---a result that we cannot afford to pass up any longer.”¹

“Providing the care that lets people live at home if they want is less expensive than providing nursing home care. It frees up resources that can help other people. And obviously, many people are happier living at home.”²

Secretary Leavitt further stated “[Home care] is not only where people want to be served, it’s radically more efficient.”³

One example of the savings our industry can provide is home photo therapy. This therapy is prescribed for infants with jaundice. The current State reimbursement of \$30 per day is inadequate to cover the provider's cost; therefore, infants who need this therapy remain hospitalized. The average treatment in the home is 2-4 days. A national average hospital stay per day as listed on the Health and Human Services website is approximately \$1,500 per day compared to a DME charge of \$150 per day for the equipment and a nurse.

It is important to note that as patient care has shifted from the facility setting to the home setting, the responsibility of providing clinical and operational services and support for the equipment has shifted from the facility to the DME provider. For example, when a DME company is providing home oxygen therapy in the home, they are not just dropping off an oxygen concentrator and portable oxygen unit like the pizza delivery guy. In fact, a national study completed for the American Association for Homecare by Morrison Informatics, Inc. dated June 27, 2006 shows that of the costs and resources required for providing home oxygen therapy for Medicare beneficiaries; only 28% of reimbursement is related to the equipment itself. A copy of the study is attached. According to this study:

Seventy four (74) oxygen services providers delivering services to more than 1.7 million Medicare beneficiaries and more than 600,000 beneficiaries receiving medical oxygen at home, completed a detailed survey, which identified the costs and resources used in providing oxygen services. Survey findings demonstrated that oxygen systems (equipment) alone represent only 28 percent of the cost of providing medically necessary oxygen to Medicare beneficiaries. Oxygen therapy in the home also requires preparing and delivering equipment, delivering supplies and maintenance of oxygen equipment, assessing, training and educating patients, obtaining required medical documentation and providing customer service for beneficiaries, other related services, and operating and overhead costs, which taken together represent 72 percent of the cost of home oxygen therapy for Medicare beneficiaries. These services are essential components of providing oxygen therapy to the more than 1 million Medicare beneficiaries who rely on this treatment.

¹ CMS Administrator Mark McClellan’s 4/27/05 testimony to House Energy and Commerce Subcommittee on Health

² HHS Secretary Leavitt’s speech to the World Health Congress on 2/1/2005

³ Secretary Leavitt’s remark to the National Association of State Legislatures on 4/15/05

As hospital and nursing home budgets have been cut, they have shifted more and more clinical and technical needs to the DME provider. Evaluations that were previously done in a facility setting are now being required by the DME provider. One example is custom compression garments. The patient evaluation was previously done by a trained practitioner. Now the referral source is calling the DME provider and asking them to complete the evaluation. The DME provider has to staff highly trained and certified individuals such as Respiratory Therapists, Certified Rehab Technician Suppliers, nurses, etc. As costs for fuel, health insurance and other operating expenses continue to rise, it is increasingly difficult to hire qualified staff.

The current durable medical equipment fee schedule in New Hampshire has not had an extensive review for over 8 years. We are currently reimbursed as follows:

- Cost plus a percentage markup of either 25%, 30% or 40%
- Manufacturer's suggested list price (MSRP) less 16% for new manual and power wheelchairs
- Fee schedule – there are two fee schedules. One is for manually priced items and shows the codes that must be billed with a description and the manufacturer cost of the product. The other has a list of codes with an allowed amount.

The problems with each of the above payment methodologies with our recommendations are:

- Cost plus methodology – Currently there is no consistency in how these codes are paid. When providers request a prior authorization, they have no idea what they will be reimbursed. Identical items can come back with differing reimbursement.
 - RECOMMENDATION – Move most of these codes to a fee schedule. This will reduce the burden on the State and providers.
- MSRP – Several years ago, the State worked with NEMED on changing the payment methodology on wheelchairs from cost plus to the current MSRP less 16% methodology. However, there are many instances where the State has paid for this equipment using the cost-plus methodology. Again, there are inconsistencies in reimbursement.
 - RECOMMENDATION – Consistency in the application of the pricing methodology.
- Manually priced fee schedule – There are delays in payments. Many claims take up to 6 – 8 months for payment processing for product that has already been provided.
 - RECOMMENDATION – Move most of these codes to a fee schedule. This will reduce the burden on the State and providers.
- Fee schedule with allowable – Although the State has assigned allowed amounts for many codes, providers must bill the lesser of the following: cost-plus or the fee schedule amount, whichever is less. It should also be noted that this requirement is not clearly specified in the provider's manual. Providers have discovered this requirement through the audit process. This payment methodology is cumbersome for both the State and the provider.
 - RECOMMENDATION – The State should pay from their established fee schedule.

There was a time when providers could shift reimbursement from other payor sources if Medicaid reimbursement was not adequate. In recent years however, providers have experienced continued reimbursement cuts from Medicare and private insurances. Additionally, DME providers are experiencing an increase in regulatory burdens, such as Congress' requirement in the Medicare Modernization Act of 2003 (MMA) to mandate provider accreditation, compliance with FDA, DOT and other regulatory bodies that continue to challenge DME providers. Providers need to be able to realize an adequate profit in order to remain in business.

We are here to work with you to improve the Medicaid program in New Hampshire. We have many cost-saving ideas that we are looking forward to sharing with you. Thank you for the opportunity to speak to you today. I will be happy to answer any questions you may have.

Respectfully submitted,

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