OHIO ASSOCIATION OF
MEDICAL EQUIPMENT SERVICES

Testimony for the Ohio General Assembly Joint Medicaid Oversight Committee

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September 23, 2021

Honorable Chairman Patton and members of the Joint Medicaid Oversight Committee:

I greatly appreciate the opportunity to be here today to discuss the Ohio Department of Medicaid's (ODM) managed care program. This program has caused numerous challenges over the years for our members and we welcome this dialogue as ODM undertakes its reinvention.

I am the immediate past president of the Ohio Association of Medical Equipment Services (OAMES). OAMES is a non-profit state trade association celebrating its 40th anniversary to advocate for cost-effective, quality care at home. We represent approximately 90 home medical equipment (HME), medical supply and complex rehab technology (CRT) providers, manufacturers and service organizations. Our providers are diverse in ownership and operations – we are small mom-and-pop companies, independently-owned regional and national organizations and entities affiliated with hospitals such as Nationwide Children's, Cincinnati Children's, Ohio Health, ProMedica, Mercy Health and more. Some of our members specialize in medical fields such as respiratory or complex mobility while others offer full-line services to patients of all ages and healthcare challenges.

I am co-founder of Central Ohio Specialty Care based in Columbus with locations in Dayton and Cleveland and a licensed pharmacist. My company specializes in the total care of children with complex needs: providing products, clinical support and technology necessary to improve the quality of life for chronically ill newborns, medically fragile children and young adults.

We welcome the chance to share our members' experiences with Ohio's Medicaid managed care program. I can speak to both the association's work with the Department and the managed care organizations (MCOs) as well as my company's issues first-hand. One of my colleagues and fellow OAMES member was planning to testify today but unable to be here at the last minute, so we've brought copies of her testimony that offers a deeper dive into the challenges HME and CRT providers face in the Medicaid managed care environment.

First, however, it's important to understand who we are as healthcare providers, where we fit in the big picture and our many years of efforts with ODM and the MCOs. Unless you've had a personal experience, it's likely you've never heard of our small but essential healthcare sector that plays an integral role in the continuum of care that not only saves healthcare dollars but improves patients' lives. Simply put, HME companies provide the products and support infrastructure to keep patients at home. With our focus in the home, we are uniquely positioned to work with patients, families, caregivers and prescribers in driving optimum health outcomes and disease management knowing

the patient's home situation, family dynamics and unique medical needs. We are in regular contact with patients and work diligently to avoid unnecessary hospital readmissions or health complications.

I'd like to mention that OAMES has had a long-standing, constructive working relationship with ODM over my 25 years volunteering with the association. In fact, just yesterday, we collaborated to host our fall educational webinar. We are proud of our work with ODM providing valuable training and developing HME rules to ensure continued access to quality HME services. The ODM Non-Institutional Policy staff and OAMES volunteers have productive on-going discussions balancing the needs of HME providers and consumers within the constraints of State spending to ensure the best value for Medicaid dollars. I might add that's a large source of our frustration with the managed care program. Stakeholder partnership including the patients, providers and payer is vital to achieving successful results administering a healthcare benefit. While we recognize the intent of ODM outsourcing many functions to MCOs, the agency must not relinquish responsibility, nor reduce transparency and culpability, that risks public trust.

As ODM expanded their managed care program years ago, transparency and accountability eroded. We continued to have access to ODM officials and MCO representatives to discuss our issues but we continually fell short of meaningful improvements. To complicate matters, while the managed care climate remains very difficult today, much of OAMES' focus over the past 18 months shifted to COVID-19 given the front-line role our providers play in caring for patients at home and expediting hospital discharges to reduce spread. I could spend hours discussing those intense measures and the incredible lengths our staff is going to persevere through these difficult times, but that's for another day.

Our over-riding concerns for Ohio's Medicaid managed care program falls into two main areas focused on transparency and accountability:

1) The Medicaid managed care program must follow the state's Medicaid DME rules, Ohio Administrative Code Chapter 5160-10. This includes the right for patients to choose the HME provider that best fits their needs which currently exists for the MyCare Ohio program as outlined in OAC rule 5160-58; and
2) Improvements must be made to the design and oversight of the Medicaid managed care program in the HME sector to ensure efficient, consistent administration and transparent, accountable outcomes.

Early on, OAMES discussed these two key issues in the spirit of collaboration with ODM and MCOs and in June 2017 presented formal recommendations which I've included with this testimony. The document outlines in great detail several areas for improving the administration of the HME benefit and working relationship between HME providers and MCOs. This includes: coverage rules, prior authorization, patient migration, claims adjudication, provider panels, access to care, and fee schedules.

To help you understand the scope of technical issues, please refer to page four of the document for a chart outlining a specific issue on prior authorization requirements. This is just one example that visualizes the confusion caused when ODM took a hands-off approach and allowed MCOs to deviate from OAC rules – whether policy, process or procedural in nature. As you can see from the document, we provided tremendous insight to improve the managed care model for HME services, one of which was the establishment of an Advisory Panel inspired by the effective collaboration between OAMES and ODM for decades. OAMES has never been anti-managed care but always for efficient, accountable, cost-effective care.

It goes without saying that following OAC rules is critical to ensure Ohio Medicaid recipients receive the full benefits established by the Ohio Medicaid program. This not only protects patients but providers as well and ensures parity and fairness regardless of the Medicaid care delivery model. Providing oversight safeguards this intention. OAMES members have encountered countless issues working with MCOs over the past several years: from operational challenges such as having clear, publicly available policy and procedures; to technical claims-processing problems that make your head spin; to heavy-handed contract negotiations or termination of contracts without cause. You may

recall the contentious issues that arose between CareSource and the Cleveland Clinic in 2017? Suffice to say, HME providers do not have nearly the leverage of the Cleveland Clinic demonstrating the lengths to which the MCOs will go to make it difficult for Ohio's providers, even those as prominent as the Clinic.

One of the most egregious practices by some MCOs in the HME sector is the use of "sole source" contracts between plans and providers that eliminates patients' choice. We strongly oppose this practice. OAMES brought this issue to ODM's attention when it first occurred many years ago and at the time, we expected they would share our concerns on behalf of Medicaid recipients. We learned that not to be the case and the practice was accepted as "innovative". This was incredibly disappointing given the lack of any objective, evidence-based assessment of these contracts and the impact on the patients and their families. Health care is deeply personal, especially when provided in the home, and this contracting approach by MCOs strips patients that fundamental right. We recognize tough decisions are made to administer healthcare programs within financial limitations but in this case, there's been no transparent measure that we're aware of by ODM or MCOs to ensure that's occurring with these contracts.

In regards to the policy, operational and technical problems our providers have experienced outlined in OAMES' 2017 document, we initially thought it was a learning-curve, an educational opportunity given the newness of the program. As history with the traditional Medicaid program has proven, it's simply a matter of working together to better understand the agency's goals and in this case, how the new MCO payment model would best work in the HME sector.

However, despite countless meetings, engagement with ODM leadership and managed care staff, as well as the MCOs directly, problems persisted. It was at that time that OAMES brought these concerns to the Ohio General Assembly. You may recall I testified, along with a Medicaid consumer, mother of a medically fragile child and a representative from the American Association for Homecare, during the State's budget hearings in 2019 in support of an amendment to bring relief to HME providers and Medicaid managed care recipients based on the key issues I noted earlier – MCOs must be transparent, follow Medicaid rules and patients must have choice. Our testimony was helpful in raising awareness but achieved no immediate relief. Soon after, we obtained a seat on the Department's Medical Care Advisory Committee (MCAC) where we understood issues would be discussed, including sole source initiatives, but that forum too has fallen short of addressing concerns and agenda topics have evolved to other healthcare challenges.

Fast forwarding to today, we commend Governor DeWine for reassessing the Department's managed care program in order to "*get the best value in providing quality care".* Absolutely, that's been our ask all along. HME plays an integral role in that goal and when ODM released the "Request for Information" (RFI) in 2019 working towards the "next generation" of Ohio's managed care program, we were optimistic to see that ODM would *"focus on the individual rather than the business of managed care"* which aligns entirely with patient choice. The association provided extensive comments to ODM's Request for Information (RFI #1) submitted July 2019 and again in RFI #2 in March 2020. Those concerns and ideas remain relevant today. OAMES is exhausting all avenues to make positive changes in the Medicaid managed care program for our providers and the patients they serve which is why we readily accepted the invitation to be here today. We truly offer an immense return on the state's investment in healthcare dollars.

I could spend a full day talking about the impact of COVID-19 on HME providers but while critical and relevant, I'll keep my comments short. We've been hit extremely hard by rising costs of products and labor shortages and the challenges of serving patients under extraordinary conditions. The global supply chain is strained causing backlogs, delays and increased costs. Acquisition costs of medical supplies and equipment are rising dramatically due to limited product availability and escalating material costs. Major HME manufacturers and distributors have implemented price increases in 2021 ranging from 3-5% as well as raising freight charges, handling fees, and adding surcharges that suppliers are forced to absorb on top of that. We expect more increases are coming in the near future which does not include the personal protective equipment (PPE) costs which have skyrocketed and are vital to protecting patients and HME employees in the home.

We share this in our testimony because we are being severely squeezed financially. Payment levels with Medicaid, the MCOs and other payers are not being adjusted to reflect these increases and with HME providers' narrow margins – especially for those served in the Medicaid program – we find ourselves in a precarious financial position as an industry. HME providers were rightfully deemed essential workers by the Centers for Medicare and Medicaid Services (CMS) and state agencies in the fight against COVID-19 and continue to make an immense difference in the lives of families each day. Earlier this summer, we made a request to ODM for funding relief through the American Rescue Plan Act that gives States enhanced federal funding for home and community-based services. HME providers need financial relief and we are anxiously waiting to hear back from the Department on that critical request.

Before I close, I also want to share concerns today about the loss of HME providers in Ohio; our healthcare sector is shrinking and the network is fragile largely due to a controversial Medicare program implemented years ago. In a recent analysis by the American Association for Homecare using CMS' data, the number of HME provider locations continue to decline throughout the United States. In Ohio, we have seen a 37% decrease in "traditional' HME supplier locations since 2013 with 11 of Ohio's 88 counties having no supplier locations, and 24 counties only having one location. While Medicare statistics, these numbers demonstrate a risk of care access for Medicaid recipients as well and should be a major concern as we navigate through the pandemic and look ahead to relying on these home-based services to manage healthcare costs, reduce hospital census and keep patients served effectively and safely at home.

In conclusion, homecare products, technology and delivery models are evolving and offer untapped potential for the future. OAMES strongly believes in partnering with our State to solve today's challenges, however, given the track record of Ohio's Medicaid managed care program in recent years, we remain gravely concerned and unconvinced that the HME sector is valued by HMOs, that ODM is willing to be hands-on in the administration of the benefit and that the needs of patients and families must be the focus. Aside from policy decisions by the plans, the MCOs' inability to simply administer claims adjudication and provide access to trained staff knowledgeable about HME remains in doubt many years later. While we appreciate their participation in on-going OAMES educational programs and stakeholder meetings, we've been unable to build a credible partnership with ODM and MCOs to better serve Medicaid recipients and work through these issues together. Our providers represent a promising strategy for tackling our state's health care challenges during and beyond the pandemic but we cannot continue operating within the current managed care environment without risking Ohioans access to quality HME services.

Thanks again for the opportunity to be with you today. I'm happy to take any questions.

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OAMES Recommendations for Improving Ohio Department of Medicaid's Migration to Managed Care

June 19, 2017

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1. **Medicaid managed care program must follow Ohio Administrative Code for consistency and transparency purposes as a tax-funded benefit**

   - ODM must require Medicaid managed care plans contracted with the State of Ohio to fully follow Ohio Administrative Code (OAC):
     - Chapter 5160-10 (durable medical equipment, DME):
       - Coverage criteria policy
       - Certificate of medical necessity forms
       - Payment tables/fee schedules
       - Prior authorization requirements
     - Chapter 5160-58 (MyCare Ohio):
       - "Participant direction" definition is *to exercise choice and control in identifying, accessing and managing waiver services and other supports in accordance with their needs and personal preferences".* A sole source or extremely restrictive provider arrangement is highly limiting by nature and defies this rule mandating "choice".

2. **Improvements must be made to the design and oversight of the program in order to create optimum efficiencies and accountable outcomes**

   - Implement efficiencies and safeguards around patient migration
   - Develop transparent and consistent claims adjudication process
   - Formalize payer-provider collaboration to insure sufficient access to care
   - Provide specific criteria and access to fee schedules, HCPCS (coding system), modifier use and prior authorization (PA) information

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OAMES Recommendations for Improving ODMs Migration to Managed Care

June 19, 2017

1. **Coverage Rules**
    a. As a condition of contracting for ODM patient populations, an MCP must, at minimum, follow the published, prevailing OAC Medical Necessity and Coverage rules for DMEPOS contained in rule 5160-10.
    b. MCPs must consistently apply the ODM standards for supporting medical documentation, proof of delivery, appeal and review processes as published in the prevailing OAC rules 5160-10.
    c. When no coverage rule exists from ODM, the MCP must publish its own coverage rule and make those rules available in advance to providers in an accessible format (Website Provider Portal).
    d. MCPs must identify and provide Website Provider Portal access for any external medical necessity databases they use to adjudicate DMEPOS claims (or any other health sector claims)
    e. MCPs must recognize and accept the current ODM required documentation requirements and specifically implement the prevailing ODM Certificates of Medical Necessity forms and completion requirements.
2. **Prior Authorization**
    a. Prior Authorization Rules must be consistently implemented from plan to plan by specific HCPC as defined by prevailing ODM requirements, unless the MCP PA requirements are **less** restrictive than ODM.
    b. PA rules changes must be published no less than 90 days in advance of any effective date and must include a published 30 day provider comment period to ODM Managed Medicaid department.
    c. PA's must be backdated to start of Care when providers request PA at start of care but time lag exists from MCP to Provider for approving a PA request.
    d. PA's must be backdated to the MCP effective start of care date for any patient who changed plans without notice to the DMEPOS provider.
    e. Approved Prior Authorizations for a specific beneficiary should be accepted across all MCPs once appropriate medical necessity has been established by the current MCP.
3. **Patient Migration**
    a. If ODM allows for patient migration from plan to plan every 30 days, the admitting MCP must notify all existing providers for that patient of the effective date of coverage within 15 days of the effective date of policy.
    b. The patient's new MCP must honor any PAs from the prior MCP back to the effective date of coverage for the new MCP.
4. **Claims Adjudication**
    a. MCPs must adjudicate claims for each health sector in the clean claim terms (30 day and 90 day) contained in the prevailing MCP/ODM contract
    b. MCPs must recognize the same timely filing limits as defined in the prevailing, published OAC rules
    c. MCPs must report to ODM and publish on their websites their method for determining clean claims payment performance for each health sector
    d. MCPs must publish on their Website Provider Portal and report to ODM their actual monthly performance on the predefined cleans claim payment standard
    e. ODM and MCPs must define a penalty for cleans claims performance issues paid directly to the providers affected
    f. Claims Issues Projects (B5 denials, Y2032 denials, Enteral NDC denials) must be categorized and reported by the MCPs to ODM monthly and published on the MCP Website Provider Portal
        i. Claims issue projects must include a predicted timeline from the MCP for resolution for each affected provider
        ii. MCPs must communicate with all affected providers when resolution timelines are missed and a new resolution timeline is established
        iii. MCPs must publish on its Website Provider Portal when Claims Issues Projects have been corrected or resolved and define what HCPC codes were affected.
        iv. MCPs cannot restrict or delay payment on **resolved** claims issues projects indefinitely. All

providers affected must be paid on the same MCP payment cycle.

v. Once a Claims Issue Project has been resolved, all affected claims become clean claims on the date of resolution and must be paid in the predefined clean claims payment timeline.

5. MCP Provider Panels

a. MCPs must not close any health sector provider network unless they have a predetermined, published method for insuring sufficient access to care for all beneficiaries.

b. MCPs must report to ODM and publish on their Website Provider Portal the number of single patient, out of network agreements for DMEPOS services on a quarterly basis.

c. MCPs must allow providers with active MCP patients to re-enroll into that MCP without penalty on price or terms when the provider has a change in ownership within 90 days of notice from the provider.

d. Referencing OAC 5160-58 and Appendix Q Payment Reform provision, MCPs cannot establish single source statewide contracts for any DMEPOS for ODM patients that limits choice and control or restricts competition among providers.

e. Although OAMES recognizes the value of payment innovation and supports the MCP's obligations to develop innovative payment processes that reward quality and patient-centered care, establish an initial provider enrollment standard for all existing ODM providers. Beneficiaries should not lose access to a preferred ODM provider due to closed MCP networks.

6. Collaboration to Insure Sufficient Access to Care

a. MCPs are required to establish a DMEPOS Advisory Panel to meet at a minimum of once per quarter to review and discuss:

i. Appropriate access to care for beneficiaries
ii. Claims Issue Projects and barriers to resolution
iii. Medical necessity issues
iv. Regulatory changes
v. New HCPCs established by the PDAC
vi. New coverage rules

b. The MCP DMEPOS Advisory Panel must include representatives from the MCPs Medical Oversight team, Case Management team, Adjudication department, PA department and Provider Representatives.

c. The MCP DMEPOS advisory panel must include at least 1 member of OAMES and 4 additional DMEPOS providers.

d. The MCP DMEPOS advisory panel must include a member of ODM's Managed Medicaid Oversight committee.

e. The MCP DMEPOS advisory panel MAY include other representatives of related health sectors (hospital discharge coordinators, Homecare Case Managers)

7. Fee Schedules

a. At the request of a Provider, MCPs must provide to ODM, similar to the Competitive Bid Bonafide Bid Challenge process (although with ODM oversight), justification that supports the sustainability of any fee schedule discounts below the ODM fee schedule.

i. Sustainability analysis must include evidence of provider invoices, direct service costs, other operational costs and any MCP payment innovation initiatives that support a fee schedule rate below the prevailing published ODM rates.

b. MCPs must establish mechanisms to recognize two digit HCPC modifiers (U1 for example) for prevailing ODM recognized specialty HCPCs (A7521 U1).

c. For Prior Authorization products like B4160 or B4161 enteral codes, MCPs must publish on its Website Provider Portal any databases they use for establishing allowable prices for items not having a published ODM allowable amount (FDA's NDC reference table)

d. For items without a published ODM allowable amount (A4606, B9998, B4160, A4649, B1399), MCPs must recognize the OAC prevailing rules for establishing the payment amount by using a Provider **Paid** Invoice within 60 days from the date of service (currently the lessor of Provider's billed charges or 1.47 times provider cost).

OHIO MANAGED MEDICAID PA REQUIREMENTS-2017

PROCEDURES AND SERVICES	HCPC	ODM FEE SCHEDULE	ODM PA?	BUCKEYE PA? WEBSITE	CARESOURCE PA?	MOLINA PA?	PARAMOUNT PA?	UNITED H.C. PA? WEBSITE
				Durable medical equipment (rental or purchase) over $500*. (*Threshold based upon reimbursement in current Ohio Medicaid Fee Schedule)	DME over $750 in billed charges. Infant Formula greater than 30 cans or 72 units (100/cal) per month.	DME follows Medicaid guidelines. ENTERAL formula does require PA	Only enteral feeding procedure codes	GREATER THAN $500. DME codes listed with a RETAIL purchase or a cumulative rental COST of more than $500.
	B9002	$679.00	NO	YES	YES	NO	NO	YES
	B4152	$0.51	NO	NO	YES	YES	YES	YES
	B4153	$1.75	NO	NO	YES	YES	YES	YES
	B4154	$1.15	NO	NO	YES	YES	YES	YES
	B4158	$0.87	YES	NO	YES	YES	YES	YES
1.47 x invoice	B4159	PA	NO	NO	YES	YES	YES	YES
1.47 x invoice	B4160	PA	YES	NO	YES	YES	YES	YES
ODM 1.47 x invoice	B4161	PA	YES	NO	YES	YES	YES	YES
1.47 x invoice	B4162	PA	NO	NO	YES	YES	YES	YES
2ND VENT	Y2032	PA	YES	NO-PAR YES-NONPAR	YES	HCPC NOT ACCEPTED	HCPC NOT ACCEPTED	HCPC NOT ACCEPTED
AIR MATTRESS	E0186	$219.74	YES	NO	NO	YES	NO	NO
Per day charge /180 days-LOW AIR LOSS	E0193	$32.50	NO	NO	YES	NO	NO	YES
Per day charge/180 days-AIR FLUIDIZED BED	E0194	$38.00	YES	NO	YES	YES	YES	YES
MANUAL BED	E0255	$677.00	YES	YES	YES	YES	NO	NO
SEMI ELEC BED	E0260	$989.00	YES	YES	YES	YES	NO	NO
PULSE OX	E0445	$2,250.00	YES	YES	YES	YES	NO	YES
VENT	E0465	$900.00	NO	YES	YES	NO	NO	YES
BIPAP	E0471	$320.00	YES	NO-PAR YES-NONPAR	YES	YES	NO	
BIPAP ST	E0472	$320.00	NO	NO-PAR YES-NONPAR	YES	NO	NO	YES
IPPV	E0481	$4,724.50	NO	YES	YES	NO	NO	NOT COVERED PER POLICY
COUGH ASSIST	E0482	$3,440.00	YES	YES	YES	YES	NO	?
CHEST VEST	E0483	$12,190.00	NO	YES	YES	NO	NO	?
HI OUTPUT COMPRESSOR	E0565	$525.00	YES	YES	YES	YES	NO	?
CUSTOM TRACH TUBE	A7520 U1	$389.55	YES	YES	MODIFIER NOT RECOGNIZED	MODIFIER NOT RECOGNIZED	NO	MODIFIER NOT RECOGNIZED
CUSTOM TRACH TUBE	A7521 U1	$404.25	YES	YES	MODIFIER NOT RECOGNIZED	MODIFIER NOT RECOGNIZED	NO	MODIFIER NOT RECOGNIZED