Mississippi Association of Medical Equipment Suppliers

Representing Home Medical Equipment Suppliers

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Definition of HME-Industry Adopted

- Delivery
- Patient and/or home assessment to verify the appropriateness and safety of the prescribed item
- Set-up
- Instruction on:
  - Use and operation with return demonstration
  - Maintenance
  - How to seek assistance in the case of operational failure
  - How to report changes in medical conditions
- Assistance in verifying insurance coverage and billing the patient's insurance
- Collecting needed documentation from physicians, hospitals, nursing homes, home health agencies and other healthcare professionals to support the medical necessity and coordinate care for such items
- 24/7 availability of assistance for after hour and holiday services, where apropriate, including natural disaster or national emergencies (i.e. tornadoes, hurricanes, floods, blizzards, etc… which necessitate additional staff, time, equipment, and resources to help prepare, respond and recover from said events)
- Acting as liaison between patient and clinician to assure appropriateness of service
- Advocating on behalf of the patient where reimbursement was challenged by the insurance carriers

How does HME Help?

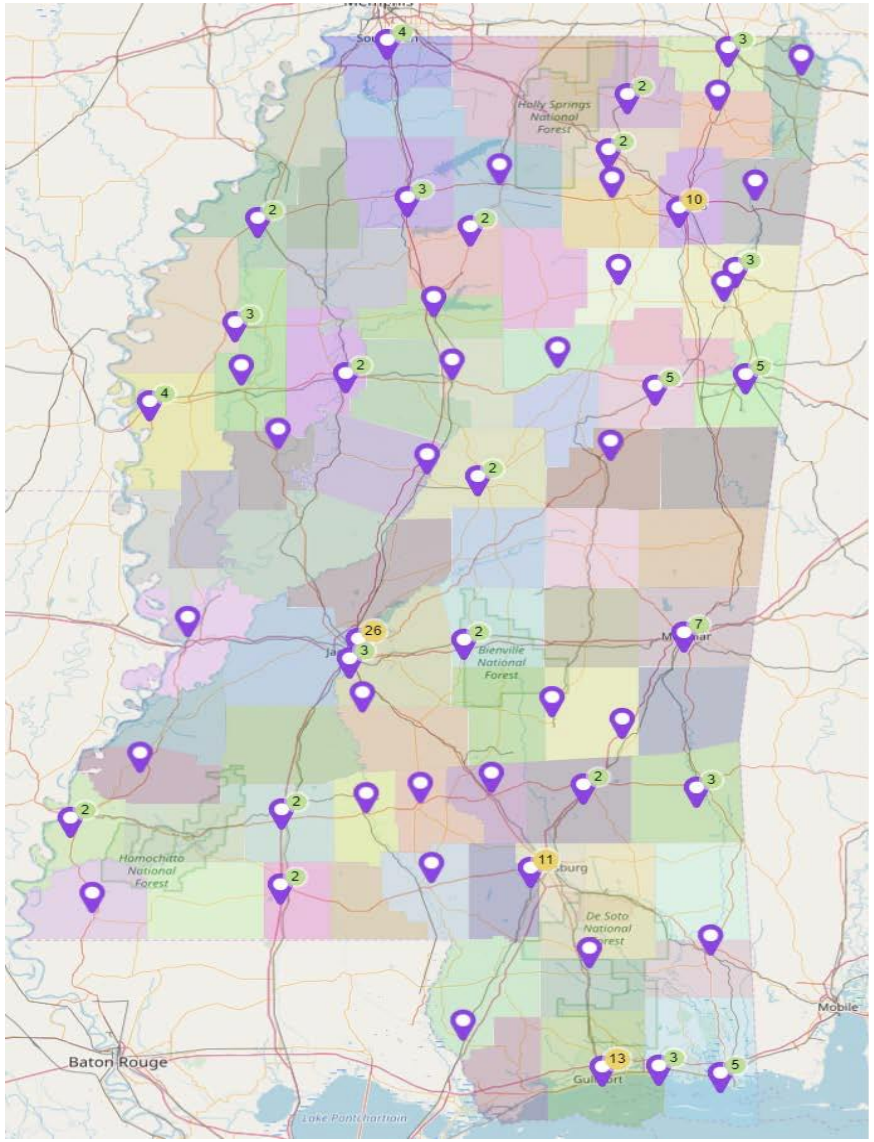
- Quite simple- HME provides equipment to patients within their home which is far less costly than inpatient settings.
- By using HME equipment, patients are less expensive in other areas of their healthcare (hospital admissions, developing other co-morbidities, fall prevention, skin breakdown, strokes, diabetes, and many more)
- HMEs employ a wide variety of skilled/certified staff such as RNs, RTs, ATPs to help patients achieve these goals. This is a value in which HMEs are paid no additional fee.
- What Covid has shown about the need for better access to HME
- See the following examples of a compliant patient:

Compliant Patient with OSA

- Patient has sleep apnea and requires a CPAP device
- DME spends at least 1-2 hours gathering documentation and preparing device and supplies
- Patient is setup by a respiratory therapist (RT) which takes anywhere from 1-1½ hours.
- After the setup, RT continues to do follow-ups with patient to ensure compliance.
- Medicaid rate for a CPAP unit- $55.32 per month. Medicaid does not cover the supplies until a patient's CPAP has been purchased (10 months). All other insurances cover supplies at the initial setup and do not wait for the unit to be purchased. Replacement of supplies is a key factor in compliance.
- What does a complaint CPAP patient mean-
  - A compliant patient means a healthier individual who is not suffering from the many different conditions that come from untreated OSA.
  - Untreated OSA can lead to excess daytime fatigue, high blood pressure, heart problems, type 2 diabetes, and even liver problems. All of these conditions are far more expensive than paying for a CPAP and supplies.

HME Supplier Market Since CB Program Implementation

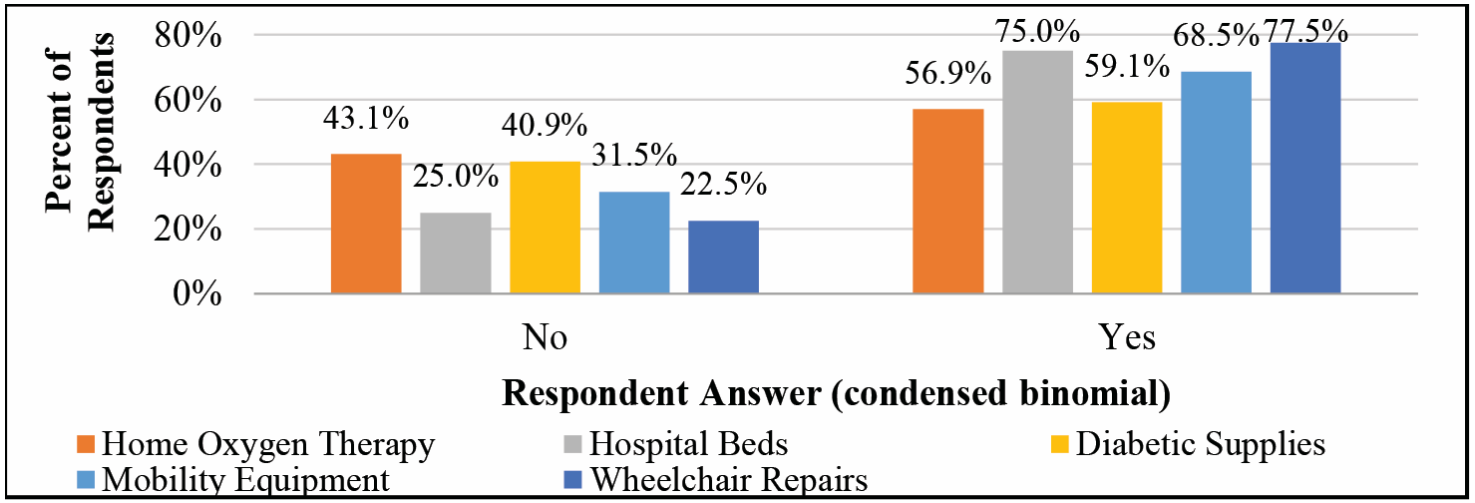
- Total of 172 locations as of July 2020
- 31% decrease in locations since July 2013.
- There are 28 counties with no DME supplier



"Traditional" Medicare suppliers - these locations provide at least two of the following product categories: hospital beds, wheelchairs (complex/ standard), oxygen, RAD, CPAP, support surfaces, NPWT, Ostomy, urological, and enteral.

Impact of Competitive Bidding on Medicare Beneficiary Access to DME

- The survey was completed by 428 patients, 358 case managers, and 266 suppliers.
- 52% of beneficiaries reported problems.
- 77.6% of case managers experienced difficulties with timeliness of discharge process due to HME access issues.
- 89% of case managers report an inability to obtain DME in timely fashion.
- ATS Peer Review Study Shows similar results



AAHomecare Survey of MS Referral Sources

Finding an HME supplier(s) to provide HME-

- Never problems- 30%
- Half of the time- 15%
- Always problems-53%

Access to HME and services provided by supplier(s)-

- Never problems- 31%
- Half of the time- 8%
- Always problems- 61%

Ease and timeliness of the discharge process-

- Never problems- 23%
- Half of the time- 8%
- Always problems- 69%

Timeliness of supplier(s) in providing HME-

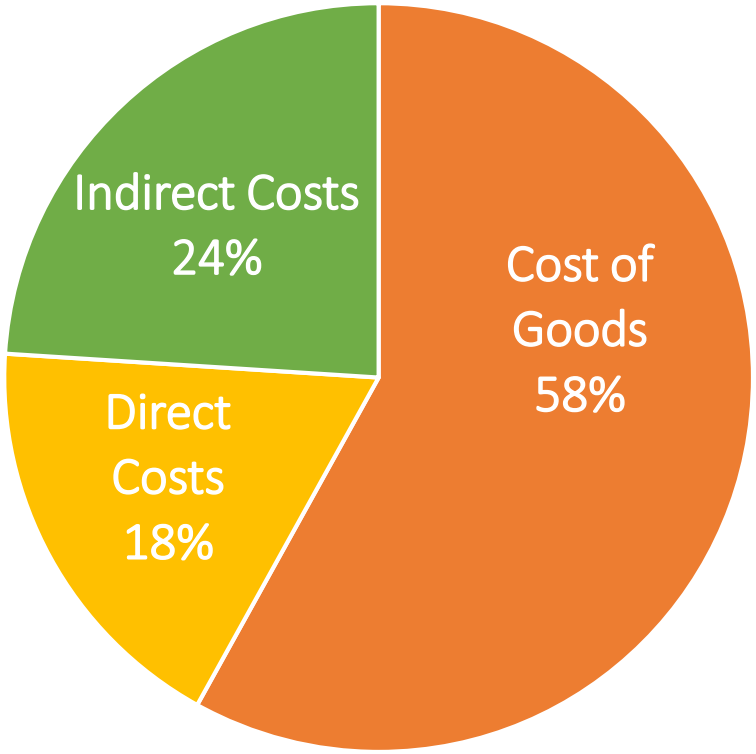
- Never problems- 23%
- Half of the time- 8%
- Always problems- 69%

Dobson Davanzo Cost Study: Proportion of Costs

- Cost of goods represents the largest proportion of costs for DMEPOS providers, yet reflects less than 60 percent of costs overall.

  -- As reflected in the Federal Register, this amount is the only cost that CMS takes into account when computing its CB pricing.

- Indirect and direct costs are those costs that are incurred by providers in the course of patient service.



Medicaid and Medicare Key Distinctions:

- Distinct Populations and Diverse Missions
- Community Verses Home Use
- Pediatric Population Cost Differentials
- Social Security Act Directive
  - Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan.

Stakeholders Request

- End the 5% Sequestration.
- Medicaid Fee Schedule needs to be clarified with the max number of units per day- this has been acknowledged as an issue, but it is causing major issues with back end denials.
- Medicaid should allow suppliers to dispense supplies up to 10 days early like other insurances allow. These claims are denied, even if Medicaid is secondary.
- CPAP supplies should be paid on initial setup and while a CPAP is being rented.
- Nurse Practitioner guidelines for ordering
- Require MCO plans to follow the same guidelines in regards to coverage as Medicaid. Ensure MCO plans cannot be more restrictive in coverage or policy than Medicaid. Differing guidelines for 4 different plans is extremely burdensome on providers.
- Continue meetings with Medicaid to handle complaints and hear problems with dealing with MCO plans. Move these meetings to occur at a minimum of every two months. Providers cannot continue to spend months fighting to get paid for claims.
- Provide Utilization Data to MAMES for evaluation by AAHomecare to determine if under or over aggregate spend to better support access to care and keep Medicaid within compliance with the Cures Act.
- Accept Proposal by MAMES for any fee schedule changes necessary to be in compliance with legislation and to address items where reimbursement is to low to provide.