April 14, 2021

Submitted electronically

Chris.McCall@house.mn

Re: Written Testimony Regarding Health and Human Services Omnibus Bill HF 2128, Durable Medical Equipment (DME) Article

To Whom It May Concern:

Numotion is a national Complex Rehab Technology (CRT) provider with several locations covering both rural and non-rural areas in Minnesota. We serve both children and adults with high-level disabilities such as Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, Spinal Cord Injury, Amyotrophic Lateral Sclerosis and Spina Bifida. Many have Medicaid as their source for healthcare.

CRT is a specialized category of DME that consists of individually configured mobility products and services, including manual and power wheelchairs, designed to meet each individual's unique and complex medical needs. These products enable individuals with disabilities to achieve the highest level of independence while preventing chronic, secondary issues that in many cases require in patient care with increased healthcare cost.

Our testimony today is to address deep concerns with Article 1 of the Health Omnibus Finance Bill HF 2128, as it includes significant rate cuts to DME/CRT services. As described above CRT is important to Minnesota's most medically fragile and is paramount to supporting their independence and mobility needs with improved healthcare outcomes. During the public health emergency, CRT providers have provided unwavering service with increase operational cost. Most of our services are already subject to Medicare rates. The proposed changes outlined are not sustainable and will create access issues to CRT that will adversely and disproportionately, increase cost in other areas.

1) Article 1 Section 50(1) (m): Proposes payment rates for all DME to follow Medicare rates.
    - Medicare rates <u>should not</u> be applied across the board for all DME/CRT HCPCs codes. It is important to understand that the Medicare pricing is set for services offered by Medicare. This Federal healthcare program was designed primarily for retired adults and limits the allowance and use of DME in the home. Medicaid's coverage expands that of Medicare, serving both children and adults with disabilities, who need their complex equipment and mobility products in the home and the community. Applying Medicare rates to all DME/CRT HCPCS codes arbitrarily, does not support the level of service required.
    - It is important to note that Congress and Medicare formally recognized the higher cost of providing CRT as well as negative repercussions of reducing reimbursement. As a result, they have permanently excluded CRT from the Competitive Bidding Program to ensure access for beneficiaries. The majority of CRT HCPCS codes were also excluded from the Cures Act.
2) Article 1 Section 50(1) (n): Proposes that payment rates for DME for which Medicare has not established a payment amount shall be the lesser of the provider's charge, or the alternative payment methodology rate. As described in clauses (1) to (4), until an alternative method is established, CRT providers will be subject to cost +20% reimbursement. This replaces the more standardized method using the universal Manufacturer's Suggested Retail Price (MSRP) model, as currently in place.
    - Acquisition, cost-based pricing is not an appropriate payment model for CRT. DME/CRT is not

a commodity. Providers employ skilled technicians like Assistive Technology Professionals (ATPs), who work with the physician and therapist closely. In many cases, our staff travel to the rehab facility and evaluate the client with the therapist to determine the proper equipment configuration. Based on this, the equipment is ordered and in some cases specially fabricated. Finally, the delivery, fitting and training is coordinated and performed with the client/family, at their location. A significant amount of time and resources go into to each equipment set up, however, the CRT provider only receives reimbursement for the actual equipment. Cost Plus method of reimbursement is not a model that supports CRT. Adopting this change will significantly cut reimbursement and will prevent delays and access issues.

    - By comparison, cost-based pricing is applied in other industries where it is only supported by large, volume purchasing with minimum processes, service and customer interaction. An example is with Retail Pharmacy where reimbursement is the "average wholesale or acquisition cost" plus dispensing fees. In these cases, the customers are served in the retail location via point of sale transaction or through mail order.

- Lastly, acquisition cost of equipment is variable among providers. These are confidential and bound by contract. The proposed "alternate payment methodology rate" based on provider's cost is a flawed and will require ongoing analysis and administrative cost for MN DHS to maintain. Alternatively, most health plans including Medicaid programs only require cost-based pricing in limited cases, where an established MSRP is unavailable. We ask the Committee to consider a tiered approach and only include acquisition or cost-based pricing as a last resort.

We strongly urge the Minnesota Legislature to consider our feedback and remove the unnecessary and unsustainable cuts to DME/CRT. It is important we protect Minnesota's most medically fragile children and adults maintain access to the services they rely on. Please feel free to contact me if you have any questions. I can be reached on my cell phone at (336) 688-2783.

Sincerely,

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