F I S C A L I M P A C T R E P O R T

SPONSOR Dow/Martinez, R/ Montoya **ORIGINAL DATE** 2/23/17 **LAST UPDATED** 3/08/17 **HB** 389/aHHHC

SHORT TITLE Medical Equipment Sole-Source Contracts **SB**

ANALYST Boerner

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Increased but Indeterminate – See Fiscal Impacts	Increased but Indeterminate – See Fiscal Impacts	Increased but Indeterminate – See Fiscal Impacts	Recurring	General Fund and Federal Match

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Duplicates SB 190

Responses Received From
Human Services Department (HSD)
Office of the Attorney General (OAG)
Department of Finance and Administration (DFA)

SUMMARY

Synopsis of House Health and Human Services Committee Amendment

The HHHC amendment eliminates the entire paragraph on page 2 which states the secretary of HSD shall ensure that no medical assistance plan reimburses a durable medical equipment supplier at a lower rate than any other durable medical equipment supplier.

Synopsis of Original Bill

House Bill 389 (HB389) adds a new section to the Public Assistance Act to require the Secretary of HSD to ban sole-source contracting for durable medical equipment (DME – a medical device that can withstand repeated use and is appropriate for use in the home). The bill outlines certain requirements and exclusions for medical plans covering DME.

FISCAL IMPLICATIONS

While the department could not provide a specific estimate, HSD argues HB 389 would increase costs in the Medicaid program because it would prohibit certain payment mechanisms recognized as effective for both reducing costs and lessening the propensity for fraud in DME. As the OAG points out, DME providers have been categorized at a higher risk for fraud by the Centers for Medicare and Medicaid Services (CMS) with a consistently and incredibly high rate of billing errors, resulting in overpayments.

HSD explains that the Medical Assistance Program does not use sole source competitive bidding programs in the Medicaid fee-for-service program because there is likely not a sufficient volume to be cost effective. However, HSD's approved Section 1115 Demonstration Waiver for the managed care program, Centennial Care, permits the Medicaid managed care organizations (MCOs) to restrict their provider networks in order to drive members to providers who offer greater value and efficiencies. Ability to manage the provider network is a key element of managed care. It may include using preferred providers or sole source contracting approaches as a way to achieve improved health outcomes, reduce fraud and garner cost savings which ultimately accrue to the state. Using preferred providers is a common feature of all states' Medicaid managed care programs and was also permitted under the former Salud! Program, which was implemented in 1997.

Consequently, HSD argues this bill would increase Medicaid program costs for the following reasons:

- Reimbursement to the MCO is made as monthly capitation payments. The contracts are "risk based" meaning that the MCO must provide all the services required within their overall capitation payments. To do so, the MCO must be given the necessary tools to manage costs and achieve value. Such actions include:

    - Contracting with providers at negotiated rates.

    - Intentionally constructing provider networks rather than accepting "any willing provider" in order to better manage under- or over-utilization of services, achieve improved health outcomes, advance value-based purchasing arrangements and construct a provider network that assures improved quality and access.

    - Contracting with vendors using sole source provisions when the vendor can provide equal or enhanced services at better value and improved quality, including contracting with transportation brokers, dental networks, glasses suppliers, medical equipment vendors, etc., as long as access requirements are maintained.

Using sole source, or primarily sole source, contracts for medical equipment is currently a feature of the federal Medicare program because it is recognized as an effective method to deliver services in an economical way. In GAO-11-337R, 2011, the Government Accountability Office (GAO) quoted CMS as projecting that sole source contracts for medical equipment may reduce program costs for those items by 32 persent. Page 13 of the report specifically references the New Hampshire Medicaid program that contracted with a single DME distributor, which has allowed New Hampshire to "secure high-volume discounts, stabilize the product line to obtain

quality control, and ease the administrative burden of dealing with multiple distributors." These are the types of efficiencies that the New Mexico MCOs hope to achieve.

Capitated payment rates paid to MCOs are constructed with the assumption that the MCO will be able to negotiate rates for certain services, including medical equipment. To the extent MCOs are prevented from having such contracting flexibility or from entering into value-based purchasing agreements with DME providers will result in increased costs to HSD.

This bill, if enacted, will increase costs for HSD because:

- It removes the ability of the MCO to take advantage of sole source contracts to the maximum extent;

- It removes the ability of the MCO to negotiate different payment rates for different providers based on location, need, costs of doing business, and available competitors at lower rates;

- It removes the ability of the MCO to drive membership to providers with a proven track record of improved quality, better management of administrative costs, less fraud and overall greater value;

- It leaves little incentive for DME providers to achieve efficiencies and improve quality since any willing DME provider will receive a contract regardless of performance, not to mention that more DME providers may enter the market once it is protected;

- It removes the ability of the MCO to obtain "best prices" because they cannot assure a certain level of volume to the contractor;

- By setting this precedent with DME providers, other providers may seek similar protections, which undermines recent advancements of value-based purchasing efforts.

See GAO-11-337R, *Issues for Manufacturer-Level Competitive Bidding for Durable Medical Equipment* for additional information.
http://www.gao.gov/products/GAO-11-337R

SIGNIFICANT ISSUES

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services. This bill conflicts with parameters set forth in Section 4.8 of HSD's contractual agreements with the MCOs related to development and maintenance of provider networks. For example:

Medicaid MCOs shall:

4.8.1.1.1 Be allowed to negotiate different reimbursement amounts for different specialties or for different practitioners in the same specialty;

4.8.1.1.2 Be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to Members.

CY 17 Delivery System Improvement Target—the MCOs must implement value-based purchasing arrangements in CY 17 with an overall target of 16 percent of all provider payments in VBP arrangements during the calendar year.

Any willing provider issue:

The bill has a requirement that the secretary shall not allow any action that "prevents a durable medical equipment supplier from providing durable medical equipment services under the same terms and conditions as those offered to any other durable medical equipment supplier."

Requiring an MCO to accept any willing provider is essentially unprecedented in the Public Assistance Act because it conflicts with advantages and efficiencies that Medicaid programs achieve when utilizing MCOs to administer the program. New Mexico has permitted the MCOs to restrict their provider networks since the Salud! program was established in 1997.

Provider network contracts and contracts with vendors in the Medicaid Managed Care program are developed based on need, price agreements and quality to assure sufficient access consistent with economy, rather than on the willingness of a provider to participate.

Sole Source Competitive Bidding Programs:
The Centers for Medicare and Medicaid Services (CMS) specifically allow Medicaid programs to award contracts to sole source contractors using competitive bidding programs to supply some specific services and items to Medicaid recipients, primarily for transportation or for tangible goods, such as glasses, medical supplies and equipment, hearing devices etc.

The GAO reported these contracts have an added advantage of reducing cases of fraud (CMS deems medical equipment providers as being in the "high risk" category for potential fraud), reducing recipient copayments when applicable, and being better able to limit overutilization of equipment and supplies.

Treating Providers Unequally:
HB 389a would establish a precedent of not allowing a MCO to treat all providers equally with regard to how managed care under Medicaid operates. The bill, by requiring a MCO to treat medical equipment suppliers differently with regard to payment and participation is essentially a special protection and treatment of the medical equipment supplier which is not extended to other providers or suppliers participating in the Medicaid managed care program and sets a precedent that may result in other providers seeking similar protections under law.

ADMINISTRATIVE IMPLICATIONS

HB 389a would require HSD to review the current NMAC rules, coverage provisions, and reimbursement provisions. The bill may require HSD to adopt and promulgate rules as well as direct the MCOs to comply. This will require revision of MCO contracts and the Medicaid Managed Care policy manual.

CB/al/jle