DEPARTMENT OF HUMAN SERVICES

Medicaid Services Advisory Committee: BRC Strategy Summary Review

May 12, 2020

Durable Medical Equipment & Supplies Rate: initial submission 420

I. Problem Statement

- DHS DME and supplies fee-for-service rates are currently 3-13% above Medicare rates and are administratively complex for DHS and providers.
- Current authority to pay Medicare rates is limited to specific supplies (those subject to an upper payment limit).

II. Recommended Strategy

- Pay for DME and supplies at the Medicare rate for those DME and supplies with Medicare rates.

III. Anticipated Benefits

- Savings to be determined. Estimate $1-$10M off the $87M DHS anticipates spending annually on DME in DHS' fee-for-service program in SFY 2020-21.

IV. Supporting Evidence

- Available evaluation evidence generally suggests maintained Medicare beneficiary access to services and satisfaction for DME and supplies paid at the Medicare rates.

V. Administrative Implications

- DHS would need to make changes to its claim payment system following legislative authorization.

VI. Equity Review Considerations

- What is the impact to those who receive Medical Assistance?
- What are the possible unintended consequences?
- What are the possible population impacts including on the older adult population?
- Evaluation of the strategy suggests the need to incorporate an itemized list of the cost for durable medical equipment.

VII. Anticipated Challenges

- Current DME providers may feel threatened by the change.

Expand DHS Encounter Alerting Service: initial submission 127

I. Problem Statement

- Providers have historically lacked notification of when their patients arrive at an emergency room, inpatient hospital unit or long-term care facility.
- Fragmented care is costly, of poor quality and contributes to poor patient experience.
- IHP providers have asked for admission, discharge and transfer alerts to support their efforts to manage their patient populations.

II. Recommended Strategy

- Expand the current voluntary program (MN Encounter Alert Service (EAS), www.mneas.org) beyond 10 IHP providers to 100% participation and provide real-time notification on ER, hospital, long-term care facility admits, transfers and discharges. Notify primary care providers to whom patients are attributed as well as care coordinators.
- Enhance alerts to include discharge summary information.

III. Anticipated Benefits

- Savings to be determined by DHS staff.
- Improved care coordination, reduced ER and hospitalization rates, reduced hospital readmission penalties and increased provider shared savings.

IV. Supporting Evidence

- Providers have been requesting the information and informal feedback to date from participating providers and patients has been positive.
- Medicare beneficiaries who had transitional case management following a discharge had a significantly lower overall mean cost ($3,358 vs. $3,033). Also, studies indicate that if necessary follow-up care is not provided after an ER or hospitalization, recovering patients are more susceptible to complications and illness, resulting in worse health outcomes and costly readmissions.
- Other states have implemented similar programs.

- A pending new CMS interoperability rule is anticipated to require hospitals to share alerts as a condition of Medicare and Medicaid participation.

V. Administrative Implications

- DHS would need to work with Audacious Inquiry (MN's health information vendor) and MDH to connect the MN EAS to the national e-health exchange.
- DHS and MDH would need to coordinate efforts with the E-Health Advisory Committee and align with the Health Information Exchange Taskforce's recommendations.
- CMS would need to grant approval and would provide 90% matching funds.
- The full implementation process, including provider onboarding, would take 12-18 months from initiation.

VI. Equity Review Considerations

- This strategy will support equity, because a) persons most impacted will be those with high ER use, including persons with mental illness and the homeless, and b) some providers disproportionately serving these populations haven't been able to take advantage of this e-health opportunity.
- How is cultural competency being considered?
- Does the strategy have unintended consequences?
- Does the strategy make provisions for accountability?

VII. Anticipated Challenges

- Provider systems would need to prioritize health IT resources. This may be more challenging for providers in multiple states and border communities.
- Providers may identify new patient care coordination needs to address.