NEW YORK MEDICAL EQUIPMENT PROVIDERS ASSOCIATION

Supporting the industry that provides quality medical equipment and services at home.

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Submitted Testimony

Joint Legislative Budget Hearing on Health and Medicaid

February 8, 2012, NYS Legislative Office Building, Albany, NY

Senator DeFrancisco and Assembly member Farrell thank you for the opportunity to submit in writing, the concerns of the New York Medicaid Equipment Providers regarding the 2012-13 Executive Budget recommendation. Representatives of the association are always available to further discuss the issues raised forthwith.

The advance of mandatory Medicaid managed care enrollment into previously exempt populations in currently underway in New York State. We join others in acknowledging the effective use of the Medicaid Redesign Team to identify a broad array of reforms so thoroughly. As you know, according to Jason Helgerson, Director of Medicaid Redesign, approximately $20 billion in Medicaid fee for service business will be transitioned into Medicaid managed care and under the governance of health plans by April 1, 2013. This is contingent upon enrolling thousands of frail, elderly, chronically ill and disabled beneficiaries into Medicaid Managed Care. That transition began with the "carve-in" of pharmaceutical benefits on October 1, 2011. Existing pharmaceutical coverage includes some items which durable medical equipment providers sell and deliver. Therefore, NYMEP members agencies experienced some complexities in the transition that we feel you should be aware of and which may influence your understanding of a renewed call for any willing provider legislation and a Patient Protection and Managed Care Standardization Act.

First issue of concern: the attached matrix illustrates that when each individual Medicaid manage care provider is authorized to choose their own dispensing method, beneficiaries cannot be guaranteed uniformity or standardization statewide. If there are 20 authorized Medicaid Managed care companies, the state can have as many as 20 prior authorization forms, justifications and processes and 20 different dispensing methods . For these reasons, we urge that you consider managed care standardization principles be put in place prior to enrollment of previously exempt populations and remain in place until insurers are more familiar with the complex needs of homebound populations.

Second issue of concern: When participating health plans learned that some durable medical equipment items could be dispensed through both DME companies and pharmacies, DME companies refused participation in the network were unable to continue to provide services to their patients. One Managed Care Plan made the decision that mastectomy supplies can only be provided by a DME provider enrolled in an IPA. which added a fiscal burden for a provider to become a member. The larger issue is that many of the Managed Care Plans closed their panels to new DME providers so for a patient who has an established trusting relationship with a provider, that patient needed to change to an enrolled provider within the network.. For this reason, we urge that new network adequacy standards be established prior to any enrollment of previously exempt populations to ensure access to the full array of necessary durable medical equipment and that mandatory maintenance of existing network participants for specialty care and services related to the needs of the currently exempt populations be mandatory and remain in place until insurers are more familiar with the complex needs of disabled and elderly beneficiaries.

This transition to managed care has triggered a new call for "Any Willing Provider" (AWP) legislation in New York. AWP laws require insurance plans to consider any qualified provider who is willing to accept the terms and conditions of a managed care plan for participation in their networks. If adequate safeguards and strong network adequacy provisions are developed AWP laws may not be necessary, but one action or the other does seem necessary to preserve beneficiaries' right to choose and right to access to quality services.

Because of NYMEP's experience with the pharmaceutical carve-in, we believe patient choice and strong provider networks under managed care for chronically ill and disabled Medicaid recipients must be governed by legislative oversight. We support enhancement of patient protections to ensure that network strength is maintained and dispensing options are available. We look forward to discussing parameters which might be considered as either temporary or permanent conditions of state contracting with health plans in the Medicaid system as we move to include fragile and complex beneficiaries into new insurance models. Such parameters might include: continuing a state role in oversight of government rate development for high-risk populations, establish an initial corridor around market negotiation of government rates; identify network adequacy measures specific to the services needed by disabled and chronic care populations; and standardize conditions of participation and contracting provisions, so that methods of dispensing, external complaints, and coverage criteria are uniform across plans offered to Medicaid beneficiaries.

Thank you for careful consideration of this testimony.

Submitted by:

Carol Napierski, Executive Director

On: February 9, 2012