Testimony for the Ohio General Assembly Joint Medicaid Oversight Committee

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Honorable Chairman Patton and members of the Joint Medicaid Oversight Committee:

My name is Carol Gilligan and I am President of Health Aid of Ohio. . I served on the Ohio Respiratory Care Board for 14 years when the board was responsible for the licensing and supervision of home medical equipment companies. Health Aid of Ohio covers services throughout Ohio with locations in Cleveland and Columbus. Since 1984, we have been providing custom wheelchairs in addition to a full line of home medical equipment (HME) and repairs. We contract with Medicaid, all Medicaid Managed Care Organizations (MCOs), Medicare and private insurers. Additionally we have the contract to provide HME equipment and repairs to all Ohio (VISN10) veterans through the Department of Veteran's Affairs

Throughout this time my team has worked with the Ohio Department of Medicaid through the Ohio Association of Medical Equipment Suppliers (OAMES). It has been a long term productive relationship spanning many administrations. We may not always agree but we meet on a regular basis and resolve issues and share opinions and recommendations.

I was asked to come share some of the difficulties Health Aid has experienced with the Medicaid MCOs. While we have certainly had good experiences, I would like to share the challenges that can be resolved with greater transparency, communication, consistent collaboration and ODM and Legislative Oversite. While ODM has been helpful when dealing with the MCOs, often times we, as providers, are told that ODM prefers to let the MCOs manage their own business. As a small business owner, this approach has led to a decay of accountability on the part of the MCOs.

My small business is more affected than large businesses by the actions of MCOs. We simply don't have the deep pockets of institutions like the Cleveland Clinic or Ohio Health to withstand inconsistent payments and policy interpretations by each individual MCO.

My overall recommendation to create an entity that meets regularly to discuss these issues for all providers. If Health Aid is experiencing these issues, surely all providers across the health care spectrum are in the same boat. A committee (perhaps under the direction of JMOC) that includes ODM, legislators, health care providers and MCOs should meet to resolve issues and share data. This data could then be shared on the ODM portal. My personal recommendations:

- What care was delivered
- Denial data and Prior Authorization Trends by MCO (% of claims denied by HCPC or CPT code)
- Take back data by MCO and reason codes
- New and Suggested Policy Changes
- Complaints
- New and Suggested Procedure Changes
- New and Suggested Reimbursement Changes

As I share specific examples of the lack of accountability and transparency, please know that these issues could all be resolved together through the proposed committee for all stakeholders.

Over the past year, I have held the business together through Covid related expenses, rapidly increasing costs for products, shipping, labor and health insurance. All without a penny in increased reimbursement from payers. Instead, we are forced to accept rates to 30 % below of Medicaid rates and payment delays are their contractual demands - or no contract. We struggle through payment delays that require additional labor and documentation to resolve with countless frustrating appeals.

Take Backs

All providers have experienced "take backs" when an insurer will make the determination that an overpayment or incorrect payment was made. ODM and CMS have a process of appeals and specific timelines. It is only when the appeal process is completed, that a take back will occur. This is not the case with Ohio Medicaid MCOs.

MCOs will notify you that they believe you were paid in error and will take the money back before the appeal process has been completed. This can be tens of thousands to hundreds of thousands of dollar and many claims will then have to be reprocessed after the appeal is won. The cost is hours of labor. There is no due process with the MCOs.

Buckeye hired an auditing company, Performant, in November 2020. Informant denied care provided to patients in a long term care facility mistakenly applying Medicare rules instead of Medicaid rules. The take back for Health Aid was $27,000. But it is just this month - 13 months later - that Buckeye appears to have straightened out the issue on their end - and will pay us for care that we delivered years ago and equipment Health Aid paid for years ago. A take back has a disproportionate impact on small businesses than large businesses.

It is even more challenging because once it has been decided that money is owed to an MCO, the MCO will quit paying other claims until the full amount of the take back is met.

When Buckeye incorrectly decided $27,000 was owed to them, they began taking the money out of current and correct claims. When it was proven that the take back was incorrect, the newer claims had to be resubmitted for payment

Because of the time that passed during the appeal process, Buckeye then denied the newer claims as not timely! They took back a combined total of $54,000 on correct claims. This is on equipment and services that Health Aid had paid for and delivered. It took more than one year to resolve the matter.

MCO Changes with No Notification or Disclosure

Some MCOs will change significant policies, procedures and reimbursement practices without transparent communication or any notification. I will say that Caresource seems to have the best system of notification. But this is not true with others.

This next example that I am providing led us to file a complaint with Ohio Medicaid and reach out to Representative Tom Patton.

In August of 2020, Buckeye changed the way that claims were to be received. They failed to notify their providers and their own team members! For Health Aid, approximately $300,000 in claims sent into Buckeye were repeatedly denied over a one year period.

Once Buckeye recognized the error, they agreed to fix the problem. After resubmitting $300,000 in claims as directed, Health Aid was told that the claims were too old/not timely/not payable. Buckeye indicated that they would not reprocess them "without good cause." After more than one year of constant work, the intervention of Representative Patton and ODM - $250,000 of the $300,000 has been properly paid. 13 months later, we are still waiting on the last $50,000.

This amount of take back was devastating and had a huge impact on this small business owner. If it were not for the inquiries of Representative Patton and the formal ODM complaint process, it is likely we would still be fighting for that $250,000. And all of this extra time and labor fighting for our payments for delivered service is funded by contracted rates 30% below Medicaid, rates forced upon us as a small businesses by national MCOs. We don't have the negotiating power or leverage of national companies.

Inconsistent Coverage Criteria
MCOs will apply different coverage criteria to patients than is found in ODM policy.
Our experience with United Healthcare is the best example of this practice.

In an effort to control spending on custom wheelchairs, United Healthcare's prior authorization department began stating that custom coded seating and positioning items recognized and covered by CMS and ODM were not "custom enough" for United Health and were not approved. Again, these are PDAC codified custom items that are nationally recognized by Medicare and ODM. Interestingly, we only experienced these denials for long term care patients of United Healthcare.

Look at the data from 1/1/21 to 6/31/21:

Health Aid has submitted 18 custom wheelchair prior authorizations to United for patients at home and in long term care facilities.

* United denied the PA requests for 29% of patients at home and 71% of patients in long term care facilities.

During this same time frame, Health Aid submitted 96 custom wheelchair prior authorizations to Caresource.

* Caresource denied the PA requests for 6% of the patients at home and 12% of patients in long term care facilities.

United seems to have singled out long term care patients and has a significantly higher denial rate than other MCOs.

Prior Authorization Issues

All MCOs fail to provide retroactive prior authorization. ODM will allow retroactive prior authorization. The two populations most affected are patients needing a repair and patients discharging from the hospital.

Health Aid has to go out about 90% of the time to assess a wheelchair for repair. If parts are needed and must be ordered, a second visit is required. Health Aid will then submit for prior authorization. Health Aid can't submit before the initial visit because the need has not been determined yet. For this reason, Health Aid must "absorb" the cost of the first visit.

To alleviate this, we were requesting patients to come to Health Aid for the initial visit. Often times this meant the MCO would have to pay for a transportation service - far more costly than the reimbursement for an initial visit by Health Aid. All of this stopped during COVID when our medically fragile patients refused to come in for the initial visit. Health Aid had no choice but to go to homes and absorb the expense on behalf of the patient.

The inability to get a retroactive prior authorization also has an impact on patients discharging from the hospital - It can take up to 30 days to get a prior authorization. When a patient leaves and needs a hospital bed, we can't provide it without prior authorization. For that reason discharge is delayed or the patient goes home without a hospital bed. If the MCOs allowed for retroactive prior authorizations as ODM does, the patient would receive their equipment immediately.

These are just a few of the glaring examples that providers could share with your committee. I urge you to consider expanding this committee's review or adding a committee to address these issues in a comprehensive manner. With transparency and access to data highlighting the need for improvement will result in efficiency and better patient care.

Thank you again for the opportunity to share these issues.

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