Highly effective habit #5: Seek first to understand, then be understood

You have taken the time to truly understand the other person's frame of reference.

The other person trusts you based on your previous interactions.

You present a good logical argument.

- We expected to be successful in our legislative attempts to avoid the decrease in the budget process legislatively.
- It didn’t happen, we were caught up short with no time left before the SPA was due to be approved by CMS.
- We opted in desperation to write letters of concern to CMS and copied them to DHCS in hopes of opposing the approval of SPA 19-0005.

- DHCS had to rapidly respond at year end to comply with the CMS directive to be less in aggregate than they would have been paid by Medicare or risk loosing their federal match

- In addition to that, they have a 10% claw back from 2011, AB 97 for our services

- In addition to that they have a state law, or statute, that states that they can't pay more than 80 % of the Medicare allowable.

- In addition to that, when the Cures Act was enacted, there was no "rural" or "non-rural" rate, and therefore, they don't have to chose the much lower "non-rural rate, but they did because they didn't look at the access problem because they look at DMEs with a very negative bias

- So, now we have a comedy of errors, each completed in a vacuum without DHCS recognizing the additive nature or full effect to DMEs and their financial viability

- The access study was a joke, it is totally ineffective and was done rapidly to comply and posted on Christmas Eve

- We decided to try to work within the “System” and wrote letters to CMS requesting opposition to SPA 19-0005. We wrote lots of opposition letters.

- CMS went back to DHCS to ask what was going on.

- In San Diego, we formed a San Diego DME Coalition

- We did a PRA to get the names and info on every DME they thought they had. It included any one who had in recent times had an MDR. That included companies who closed such as The Scooter Store, and any manufacturers who handled any kind of DME items such as diapers, orthotics, breast pumps, complex rehab only, etc. Yet they assumed that these DMEs would meet the needs of their Medi-Cal beneficiaries

- They listed 104 DME providers in San Diego, the third largest in the state of California. After we contacted them, there were actually 11 full service DMEs. Of those 11, only 2 had provided more than $10,000 worth of Medi-Cal full service DME in fiscal year 2018-2019. So, they had grossly over estimated the DME providers available.

- Through PRAs (Public Report Act) , you can get an incredible amount of information such as:

Licensed vs. Enrolled FFS DME Providers
Licensed by MDR (DPH), Enrolled to provide MediCal by DHCS

County	Licensed	Enrolled FFS
Alameda	44	24
Alpine	0	0
Amador	0	0
Butte	10	9
Calaveras	1	0
Colusa	0	0
Contra Costa	27	8
Del Norte	0	1
El Dorado	5	4
Fresno	49	30
Glenn	0	0
Humboldt	4	4
Imperial	0	5
Inyo	1	1
Kern	24	11
Kings	1	2
Lake	3	3
Lassen	1	1
Los Angeles	293	376

County	Licensed	Enrolled FFS
Madera	1	0
Marin	0	2
Mariposa	0	0
Mendocino	2	3
Merced	3	7
Modoc	0	0
Mono	1	
Monterey	7	5
Napa	1	1
Nevada	2	3
Orange	100	78
Placer	13	4
Plumas	1	1
Riverside	64	34
Sacramento	105	24
San Benito	0	0
San Bernardino	71	63
San Diego	104	62
San Francisco	18	11

County	Licensed	Enrolled FFS
San Joaquin	0	13
San Luis Obispo	10	11
San Mateo	21	16
Santa Barbara	7	8
Santa Clara	44	21
Santa Cruz	8	5
Shasta	17	11
Sierra	0	0
Siskiyou	3	3
Solano	10	8
Sonoma	11	9
Stanislaus	14	10
Sutter	4	5
Tehama	0	0
Trinity	0	0
Tulare	7	9
Tuolumne	1	1
Ventura	37	29
Yolo	6	1
Yuba	0	0

- Number of MDRs per county and their names
- Medical dollars paid in your county by HCPCS code for fiscal year 2018-2019 and to whom it was paid
- Top 20 providers in the state rank ordered by sales in a given HCPCS code, by both FFS/CCS and managed care

What we did:

- 1. Formed a coalition, called everybody and we met face to face.
- 2. Came up with an action plan to call and detail a report of who the DME providers were in our county
- 3. We talked to each other and established a rapport and got out of our silos
- 4. Started writing letters to CMS, DHCS, and invited DMEs from other areas in to join us
- 5. Formed a Google group to be able to talk and disseminate info

What we did:

- 6.Kept notes and had phone calls to discuss the project, including progress and updates
- 7. Continued to try to talk to DHCS and CMS to seek to understand before asking to be understood
- 8. Wrote position papers and started to contact our referral sources, and DHCS.
- 9. Got ready to speak to our Legislators for support to talk to DHCS

Outcomes

- 1. We got to know each other and are building a support mechanism and develop trust between our local colleagues
- 2. We spoke to DHCS. In the last two days, we have gotten a response that:
- A. CMS has asked DHCS for an RAI (Request for Additional Information). They will not approve the SPA until they have info that will support and answer the concerns we have raised in our letters
- B. DHCS is looking at this issue and concerns over access for DME “at the highest levels”
- C. DHCS must complete a more involved access study and support to give to CMS before CMS will look at approving the SPA

Outcomes

- D. DHCS is “looking at methodologies and administrative alternatives” to soften the financial blow of their attempting to comply with the Medicare Cures Act requirements. The 80 % of Medicare is a state “Statute” which means they can’t administratively reverse that without the legislative branch passing a change in a budget or trailer bill
- F. They aren’t required by law or CMS to use the non-rural rate, as they must comply with the 2016 Cures Act. At that time, there was no rural or non-rural rate
- G. DHCS had the power to administratively reverse the 10 % claw back if they were convinced that it compromises access for their beneficiaries.

Outcomes

- Their statement is that they heard us, and they want to work with us. They would like statements from us that if they push through this reduction, we will not continue to accept the Medi-Cal beneficiaries so that they can demonstrate an access issue without us having to go through the extreme measures of having to reject referrals or refuse patient care.

What's our ASK ?

- 1. We want rural rate for the whole state
- 2. We want the 10% claw back to be relieved and stopped
- 3. We want them to amend their SPA 19-0005 request to CMS with those two items and make it effective concurrently, not retroactively

Rates

- What impact will that have? Let's look at the rates:

TOP HCPCS	OLD RATE	MEDICARE (NON-RURAL)	NEW MCL/CCS	Reduction	MEDICARE RURAL	**OUR ASK: MCL IF TAKEN OFF MEDICARE RURAL STILL WITH 10% REDUCTION**	Ask w/10% Reduction	**OUR ASK: MCL IF TAKEN OFF MEDICARE RURAL AND NO 10% REDUCTION**	Ask Reduction
E1390	$144.74	$65.70	$47.30	67%	$134.71	**$96.99**	33%	**$107.77**	26%
E1392	$41.30	$37.64	$27.10	34%	$44.32	**$31.91**	23%	**$35.46**	14%
E0431	$24.34	$17.09	$12.30	49%	$24.00	**$17.28**	29%	**$19.20**	21%
E0601	$80.55	$39.39	$28.36	65%	$74.41	**$53.58**	33%	**$59.53**	26%
E0562	$23.04	$13.14	$9.46	59%	$22.38	**$16.11**	30%	**$17.90**	22%
E0470	$188.51	$103.83	$74.76	60%	$180.39	**$129.88**	31%	**$144.31**	23%
E0570	$12.88	$5.05	$3.64	72%	$12.36	**$8.90**	31%	**$9.89**	23%
K0001	$47.30	$21.83	$15.72	67%	$42.91	**$30.90**	35%	**$34.33**	27%
E0143*	$85.69	$46.21	$33.27	61%	$80.86	**$58.22**	32%	**$64.69**	25%
E0260	$132.54	$58.30	$41.98	68%	$102.40	**$73.73**	44%	**$81.92**	38%

* Purchase Amount

- How can we maximize our Medi-Cal reimbursement and therefore remain financially solvent in order to be able to continue to serve our patients?

Calculation is :

- Medicare rate x 80 % by statute less additional 10% claw back
- What are the factors here?

- Medicare rate
- A. We are currently bidding on the new Medicare rate now, which represents not only the reimbursement rate for Medicare for the next 3 years from 2021 to 2024, but is also the basis for a lot of other players like Medi-Cal, Tricare, the Blues, etc.
- We can impact that rate with our bids

- In the nearer term, we can adjust that rate greatly by pushing for rural vs. non-rural Medicare rates as the basis. That is within the DHCS administrative control, and can be done if they choose to do so. Convincing them that they will have an access problem will be the key point here.

- The 10 % claw back is within DHCS' administrative control if they are convinced that they will have an access problem if they continue that additional hit after the Medicare reduction
- The 80 % reduction of Medicare rates is in statute or state law. They can't change that administratively without a change legislatively.
- Next year, we have to ask for Legislation to undo that 80 % of Medicare law via either a budget item, or a trailer amendment bill

So, Now what do we do?

- Form a more cohesive industry group and get involved
- Write letters or sign a mass letter to DHCS stating that access will be compromised
- Get ready to contact our Legislators and continue to fight within the system, in addition to the action plan outlined by the previous speaker

- Bid your Medicare competitive bid thoughtfully as it is the basis for all of our reimbursement rates into the future

- Remain optimistic… Always look on the bright side of life