Oversight of Durable Medical Services: Key Considerations for Health Plans

Health plans increasingly will be required to manage, monitor, and oversee a broader range of services as more states contract for managed long-term services and supports (LTSS). Oversight includes preventing fraud and abuse, which requires ensuring that the services billed are actually provided. Oversight also involves ensuring adherence to service plans that support members' goals for maintaining suppliers may be a new activity for health plans. This brief highlights considerations for developing DME supplier oversight mechanisms.

Key Considerations

- **Understand vulnerabilities associated with DME suppliers.** DME has been identified by the federal and state governments as a high-risk area for fraud in the Medicare and Medicaid programs. Understanding the challenges associated with DME suppliers and methods to address these issues may help your plan implement appropriate solutions. For more information about Medicare program integrity issues related to newly enrolled DME suppliers, see the U.S. Department of Health and Human Services Office of Inspector General (OIG) report. Additionally, for one state's perspective on combatting fraud and abuse, featuring a section on DME, see Florida's overview.
- **Review state and federal regulations.** The state will have specific regulations and requirements related to DME suppliers, and specific federal regulations will apply for Medicare health plans. Note that regulations may affect your health plan's oversight of DME. Review your contract with the state to determine your responsibilities.
- **Verify supplier accreditation**. If your health plan is serving Medicare beneficiaries, your DME suppliers must be authorized and credentialed. All DME suppliers, unless otherwise exempted, must be accredited by one of the 10 Centers for Medicare & Medicaid Services (CMS)-authorized accrediting organizations. For more information on the accreditation process, visit the CMS DMEPOS Accreditation page.
- **Monitor terminated provider lists**. The National Supplier Clearinghouse is responsible for enrolling DME suppliers in Medicare, issuing DME supplier numbers, and ensuring that suppliers comply with federally mandated standards. If these standards are not met, the National Supplier Clearinghouse will revoke the supplier number, terminating the

People Dually Eligible for Medicare and Medicaid

Your health plan likely has experience providing DME to its members. However, if your health plan is caring for dually eligible beneficiaries, there are additional considerations. Dually eligible beneficiaries are a highly varied and often medically needy population. The population includes low-income seniors and people with disabilities; dually eligible beneficiaries may have multiple chronic conditions and require LTSS. These individuals may be higher utilizers of DME services.

CMS has developed state profiles on Medicare-Medicaid enrollees. For more information, see the profile for your state at the **Integrated Care Resource Center website**.

supplier from the Medicare program. Your health plan may be prohibited from authorizing payments to suppliers terminated from the Medicare program. Check your health plan's contract with the state to determine your responsibilities for monitoring terminated providers. For more information on the National Supplier Clearinghouse, see their website.

- **Consider methods of oversight for new suppliers.** Establishing oversight procedures for new DME suppliers ensures a basic level of compliance from the outset. One method of initial oversight is requiring a pre-enrollment site visit for all suppliers to verify information submitted on the provider application. Another method to consider is adding a fraud and abuse training for DME suppliers as a provider contract requirement.
- **Establish methods for ongoing monitoring**. Ongoing monitoring methods are necessary to ensure that DME suppliers continually adhere to contractual requirements. One option to consider is conducting unannounced site visits to DME suppliers to assess onsite inventory and to verify the onsite management personnel and subcontractor information. Additionally, closely monitoring prior authorization for DME may assist in identifying fraudulent providers or suppliers. Targeting providers with a high volume of claims for a more thorough review may be helpful as well. Your health plan can also ensure that your claims system includes service limit edits and that obsolete codes are removed from the system. It is also possible to establish performance incentives for DME providers to encourage appropriate and cost-effective use of DME service alternatives.
- **Consider methods to monitor quality.** Data from member surveys can identify negative experiences with specific suppliers and possible unmet needs. You can also specifically query your members regarding provider responsiveness and timely provision of equipment. This information can be used to monitor adherence to members' service plans and to ensure that the supplies are provided as billed; members also can confirm whether services have been provided as specified in their care plans. Members may also note oversupply as an issue; DME suppliers may rely on automatic replacement services of products, resulting in too many products for the members' needs, and thus inappropriate expenses to your health plan. Additionally, to improve member adherence to their care plan (including proper and consistent DME use), instruct your providers to offer training to members or members' caregivers. Your health plan can follow up with individual members as a quality check to confirm they were properly trained on the use of their DME. Encounter (claims) data from your health plan's DME providers can be used to compare DME provider performance and identify outliers. Your health plan may be able to access statewide encounter data that could provide additional data for your network provider assessments, which may be conducted on a routine (e.g. quarterly) basis.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com/