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## CCDC Comments on Durable Medical Equipment Rate Review

The Colorado Cross-Disability Coalition (CCDC) is a statewide disability social justice organization. We represent people with all types of disabilities and the majority of our members are Medicaid clients. We have a substantial population of people that rely on Durable Medical Equipment.

We want to comment on

- a) Barriers we see regarding DME access in Colorado.
- b) Why DME payment should not be connected or compared to Medicare
- c) Proposal for a better payment model

We cannot overstate the importance of durable medical equipment to people with disabilities. Power wheelchairs are the most common form of DME that we encounter. For those of us who require continued use (meaning we do not walk at all) the seating system has to be customized. Chairs must have a certain level of durability, particularly for those who work or have other responsibilities. People who live in rural areas may need special features such as wider tires and stronger forks to get over rougher terrain. Other DME includes shower chairs, which often must also be specialized to fit the individual, patient lifts, manual wheelchairs, power assist devices for manual wheelchairs, and much more. While DME items can be expensive, DME is almost always a prevention tool. While a seating system might cost \$20,000 a pressure sore can cost close to \$1 million. Home ventilator systems are very expensive to maintain, but the only alternative is placement in an ICU, which is astronomical. It is well settled that people with disabilities and chronic illnesses who get out of their homes, and work or engage in other community responsibilities are healthier than people who are forced to sit at home, focusing on what is wrong. Anyone forced to sit in their home with no escape will have mental health problems. DME allows people with significant disabilities to live independently, work, volunteer, raise children, care for elderly parents and otherwise engage in the responsibilities of a citizen. If we are going to have a "Colorado for All" as advertised by our Governor, we must assure that Medicaid clients have access to DME.

As clients and advocates we see the following barriers regarding durable medical equipment.

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- 1) Very few providers and some parts of the state with only one provider for complex rehab. Complex rehab is what most people with disabilities require. Over the past decade we have seen a dramatic reduction in the number of companies providing complex rehab. Because of the lack of competition, people do not have choices. Without choices, it is hard to rebuff suggestions of the salespeople when that company also determines if you will get repairs. One also has no way to compare products.
- 2) No education of clients about what to expect from a DME provider. This includes no education about wheelchair and assistive technology lemon laws or how to assure that expensive equipment meets the client needs before signing that they have received and approve of the equipment.
- 3) No standards for timeliness of repairs or requirements to keep people mobile. No enforcement of lemon law requirements for appropriate loaner chairs. No accountability for mobility after one year of ownership despite the fact that wheelchairs are expected to last at least five years.
- 4) Continued confusion of Medicaid criteria with Medicare criteria.

We are aware that this committee regularly compares rates to Medicare rates. In most situations, this makes sense as Medicare rates are often fair, and based on research. However, this cannot be the case for DME, at least not all DME. Medicare and Medicaid have very different criteria.

Medicare ONLY covers what one needs to get around the four walls of the home. Medicare does not cover what one needs to live in the community. Medicare will not cover a wheelchair if someone can walk, even if they can only walk a couple of steps, or even if walking causes much pain and makes the person dysfunctional. Medicaid covers chairs that will facilitate people to live in an integrated fashion in the community. This means that Medicaid will cover chairs that are useful both indoors and outdoors, while Medicare only covers indoor chairs. Medicaid covers features that people might need because they are active, for example a tilt system for someone that sits all day might not be necessary for someone that never leaves home and spends time in and out of bed. Similarly, strong forks that can withstand city streets, railroad tracks, and country dirt roads are only necessary if one is out and about in the community.

It is imperative that there be no comparison with Medicare rates, at least for wheelchairs. It is a completely different benefit. Ironically, the federal government prohibits Medicaid from having a homebound requirement, while Medicare has this requirement. A homebound requirement means that certain services are only provided if the client only leaves the home infrequently for medical appointments. (Even death row inmates get an hour a day outside but disabled and elderly people that must rely only on Medicare without Medicaid are required to stay inside all of the time if they need certain equipment or services).. Many of the items that Medicaid covers are not even available under Medicare including:

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- -Group Four wheelchairs, which are the types of wheelchairs most active disabled people require.
- -Pediatric wheelchairs (Medicare is a program for seniors, and adults with disabilities)
- -Pediatric feeding chairs
- -Items that are necessary for outdoor use such as bullfrog forks, high speed motors, strong shock absorbers, etc. This also includes items such as devices to hold oxygen equipment on a wheelchair for safe travel, smaller portable oxygen for travel, etc.
- -Backup wheelchairs

These items have no comparable Medicare benefit so if the pricing is based on Medicare these items will be artificially deflated. Another important factor is payment for clients who are dual eligible and have Medicare as a primary source. Medicaid pays 20% of the Medicare payment. However, for clients that need a group four wheelchair what can happen is Medicare only approves a group 3, which is a lot less than a group 4. Medicaid then pays 20% of a group 3 chair. This is not acceptable. Funds to pay the real cost of this equipment are essential.

Example: Chair client needs costs \$15,000

Medicare will approve a chair for \$10,000 and pay \$8,000

Medicaid then pays \$2,000 even though the chair was prior authorized for \$15,000.

Vendor is out \$5,000

The only solution for this is to make sure the medical necessity letter is clear about the community aspect and hope Medicare denies the whole chair, which is not a good solution. Vendors often are not interested in serving clients who are dual eligible. People under 65 who are dual eligible are in that situation because the client had a work history. Clients should not be subjected to an inferior chair because the client had a work history.

Repair is the biggest challenge with the DME benefit. Again, Medicare has no or very low expectations of repair. If someone never leaves the home except to see doctors they will likely need fewer repairs as they will not wear out tires or other components and if they do not have their equipment they likely stay in bed. However, Medicaid clients are hopefully active in the community.

With at least the largest provider the repair process is painful. With DME most often the client will not be able to get to the repair shop. Some equipment like a patient lift or a bed is not moveable. If a wheelchair is broken, the client cannot get anywhere. Even if

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the client has a backup chair, there is no way to move a second a chair to another location. While a few clients might have both a personal wheelchair van and someone available to assist with getting broken equipment in the van and to the company, that is going to be rare. While some breakdowns are predictable and can be prevented with quick service when there is a strange noise or other telltale sign, many repairs are unpredictable and not preventable. Motors are a great example, they will just die with no notice. Once a motor is dead the chair cannot move.

- 1) Client calls: Often the client is told no one can get to them for weeks. CCDC regularly intervenes and if someone with enough power goes high enough up in the company, a repair tech might be sent out that day. Some clients do get quick service- but many do not.
- 2) The repair tech will go to the client and document the problem. Rarely is the problem fixed that day. Clients are routinely told that there are no loaners or that Medicaid will not cover loaners.
- 3) The repair tech puts in an order. Without intervention the company will “verify” that “funding” is available. Even though Medicaid rarely requires prior authorization they submit a PAR request. After Medicaid approves this (10-days) an order is submitted.
- 4) When the order is received the client is called to schedule the repair.
- 5) The repair tech comes and at least half the time the order is incorrect. The process repeats.
- 6) Finally the repair is completed.

We also hear often that people have the same repair done numerous times. When there are repeated repairs the client is pressured to replace the chair, even when it is clear that there is a lemon component. Sometimes it IS appropriate to replace a chair when it is too hard to replace or when it reaches a certain age.

We have had several cases recently where clients have been told that Medicaid will not pay for repairs to backup wheelchairs. In some of those cases while someone is waiting for the repair process to complete, the backup chair which is usually very old and not really suitable for use for more than a few days, breaks and then the client is told they cannot get it fixed. Sometimes the backup chair is at the shop so long that when the primary chair breaks the backup chair is not available.

Anyone who depends on a wheelchair for mobility must have either a backup chair that is usable and appropriate OR be assured of getting repair within a few hours, something that is only realistic on the Front Range. If there is no appropriate backup and there is not an equivalent loaner, the proper procedure is to put the client’s seating system on a loaner base. Putting a client in a chair that has a different seating system can be dangerous. We are aware of clients who have obtained pressure sores from this and

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Medicaid then had to pay for surgery and extensive rehab from just two days of being put in the wrong chair. Providing a client who is active and uses public transit with an indoor only chair that cannot go fast enough to cross a city street safely is also dangerous. Expecting that a client will sit inside for weeks or months just because their loaner chair is not made for outdoor use is not reasonable. Moreover, those who work need to be able to get to work. Parents need to be able to take their kids to school.

We have also experienced many situations where a client knows something is going wrong, they call the company, and because the process is so long it becomes an emergency. One example was a loose joystick and because it was not fixed timely, the joystick fell apart while the client was driving a modified van causing a serious accident. The van was totaled and injuries occurred. It could have been much worse.

Financing for repairs must include the following:

- 1) Assumption that many repairs must happen immediately. Even those that do not need to happen immediately should never wait months, or even weeks.
- 2) Due to the monopoly any provider that has a monopoly must be required to provide statewide access.
- 3) Providers over a certain size should be required to have inventory that includes several loaner bases of popular group 4 four chairs such as Invacare and Permobil.
- 4) HCPF should be required to eliminate ALL prior authorization for repair and instead a robust post pay review should be implemented. If HCPF would implement the law passed in XXX that requires clients to be provided copies of what is billed in our name we could help with any inappropriate billing.
- 5) The system should also look to make sure repairs for warranty work are not billed. Moreover, adjustment that should have been taken care of with the original sale should be covered by the vendor. Genuine changes in client conditions should be covered by Medicaid.
- 6) Travel funds must be provided as well as shipping costs including overnight costs of highly specialized items that are not reasonable to have in inventory (e.g. custom head rest that only one client could use).

Sales should also be examined not only by medical staff but by people that understand complex rehab and independent living. For example:

- 1) If someone is an active person they should not be sold an indoor chair. Some vendors do this because it is easier to just deal with Medicare rules than do what the client needs.
- 2) Durability should be assessed.
- 3) Warranties for accessories should be reviewed. For example bullfrog forks are excellent forks that have a lifetime warranty even though they are more

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expensive than regular forks, regular forks will break several times a year for active users with neurological disabilities.

- 4) Client seating systems should be put on loaners.
- 5) Backup equipment must be usable by the client. If someone is unable to safely propel a manual wheelchair there should be a good explanation before allowing a manual chair as a backup.
- 6) Pain management is a legitimate function of DME and seating. Often if seating is not right people end up in pain so severe that they end up in emergency rooms because blood pressure and other vital signs get out of control when pain is severe enough. If HCPF wants to help people reduce the use of Opioids, then seating and positioning must be provided appropriately as part of the DME benefit. The medical necessity definition says that something is not medically necessary if it is solely for the comfort of the client or convenience of the caregiver. Reviewers must understand that comfort and pain management are different. Just because on notes a client says a new chair or a seat is "more comfortable" does not mean it should be a red flag for denial.

Payment reforms should be considered: While we are aware this is about rates, we need to consider how we pay.

People that use complex rehab are unlikely to leave the Medicaid rolls. People did not increase income until Medicaid Buy-In for working adults with disabilities was implemented. If someone is disabled enough that they rely on this level of equipment, it is unlikely that this individual will be able to forgo Medicaid so there is little risk of churn in this population. When assessing payment and risk they should be seen as long-term clients. They generally leave Medicaid when they die.

- 1) Consider a global payment to keep someone mobile and as comfortable as possible. This means assuming a 5 year life of wheelchair and reasonable repairs (motors every few years, tires twice a year, etc.) DME vendors should be paid a PMPM to assure mobility. They can use this to have sufficient resources. They must assure certain quality standards such as motors that are fast enough to be functional and safe, decent seating, shock absorbers, and client choice of important features such as mid or rear wheel drive and assuring the chair will fit in the home and be usable with the client transportation system. Instead of a 100% payment for a new chair and then a fee for service model of payment for repairs, pay something substantial for the purchase but then average the costs for maintaining. If a DME vendor does preventative work, keeps adequate parts, and is timely with repair responses they will make money. If they cause crises and have to fed-ex parts and make multiple trips they will lose money. They must have enough to have inventory. Payment should consider travel with extra funds for rural clients. Vendors can be free to hire local people including bike and car mechanics to serve those in rural areas using face time or technology for

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- supervision. This should be piloted in an urban and rural area. Clients, providers and someone with access to HCPF billing data should be part of the design. A RAE could be used to administer this pilot.
- 2) Address additional needs with delivery reform. A partnership with DVR or workforce centers could prove fruitful in providing appropriate services in rural communities. Most repairs consist of removing a broken part and replacing it with a new part. DVR clients who have disabilities other than severe physical impairments such as people who are Deaf, have mental illness, or learning disabilities can be trained to do most repairs. They can work in their local community. DVR funds, which are mostly federal, can be used to set people up with initial tool purchases and initial training. Supervision can be done via Skype or Face Time. Medicaid can be billed and the contractors can be paid. This makes more sense than having someone drive hours to do a repair, often requiring the client to wait risking injuries caused by immobility in the process. This will also get people with disabilities employed which benefits the economy.
  - 3) Allow telehealth for wheelchair evaluations and allow more people to do the evaluations. The need for proper evaluation before purchase of a wheelchair is important and we supported this concept for complex rehab. However, there are often not people available to do the evaluations, causing people to get chairs that do not require this and therefore get simpler chairs that break quickly because they are indoor chairs being used everywhere. Requirements on replacements should be loosened.
  - 4) Allow clients to order supplies online and submit for reimbursement or even provide vouchers. Many supplies can be purchased at a fraction of the cost online. People could also buy in bulk and save money.
  - 5)