National Coalition For Assistive & Rehab Technology

January 29, 2018

VIA ELECTRONIC DELIVERY to http://www.regulations.gov

Mr. William N. Parham, III
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Attention: Document CMS-10661
Room C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Comments on Document CMS-10661: "Limit on Federal Financial Participation for Durable Medical Equipment in Medicaid"

Dear Mr. Parham,

These comments regarding document CMS-10661 are being submitted on behalf of the National Coalition for Assistive and Rehab Technology (NCART). NCART is a national association of leading suppliers and manufacturers of Complex Rehab Technology (CRT) products. Our members operate over 350 Medicaid supplier locations across the country, serving tens of thousands of Medicaid beneficiaries in their communities.

NCART works with legislators, policy makers, and third-party payers to ensure individuals with significant disabilities and chronic medical conditions have adequate access to CRT products and related services. CRT products include medically necessary and individually configured manual wheelchairs, power wheelchairs, seating systems, and other specialized adaptive equipment. This specialized equipment requires evaluation, configuration, fitting, adjustment, or programming to meet the medical needs of people with disabilities and maximize their function and independence.

Adequate access to CRT not only provides function and independence, but also plays a key role in keeping health care costs down by reducing medical complications, clinical interventions, hospitalizations, institutionalizations, as well as caregiver assistance and additional services.

We appreciate the opportunity to submit public comments on document CMS-10661 regarding the "Limit on the Federal Financial Participation" (LFFP) and provide our comments and recommendations below:

1.) To date, CMS' publication and implementation of this 21st Century Cures Act provision has created a great deal of uncertainty and confusion amongst State Medicaid Departments and Durable Medical Equipment (DME) and CRT suppliers. The first note on this issue is that the official Medicaid Directors Letter from CMS was not issued until December 27, 2017. That was just 4 days before this provision was to go into effect. In addition, we are 29 days past the effective date and COMPLETE information and instructions are still not available. Missing information includes

critical details such as: the list of specific DME codes that will be impacted; and a full identification of the options a state has under the LFFP provision. Confusing information includes such things as: giving the impression that this impacts all DME codes, not a limited number; and not fully accounting for the differences that exist between the coding and payment methods of the national Medicare fee schedule and each of the 50 state Medicaid fee schedules. Such things as rental vs. purchase payment methodologies will create comparison challenges. There is also an over-emphasis within CMS communications that encourages states to just unilaterally adopt the Medicare fee schedule for all codes.

2.) The original provision in the Consolidated Appropriations Act of 2016 that contained this LFFP also required CMS to do a study of the impact on access of cutting Medicaid DME payment rates to Medicare levels. This critical evaluation has not been performed yet. This language was included by Congress as it recognized an action like this should not move forward until CMS had fully evaluated the impact it may have. The language also required the evaluation be made public. CMS was aware of this requirement upon passage of the Appropriations Act in December 2015 which allowed sufficient time for such a study to be conducted. Since we have neither heard of, nor seen, such a study we are recommending a delay be placed on the implementation of the LFFP until this critical evaluation is completed and published.

3.) The Medicare DME Competitive Bid Program rates were developed for the Medicare population, not the Medicaid population. The Medicaid population is very different. When establishing payment rates, it is important to recognize the needs of the beneficiary population. The Medicare population, which was the basis for the Medicare rates, is much different than the Medicaid population. The Medicare population is primarily elderly in nature and has a small population enrolled based on being disabled. In contrast, the Medicaid population represents all age groups, including a significant pediatric population. It also has a higher number of individuals with disabilities. Based on these differences, the types of equipment and related services can vary between Medicare and Medicaid. These are all factors that must be considered in studying what impact an adoption of Medicare rates at the Medicaid level may have.

4.) The Medicare DME Competitive Bid Program rates that are being used as a benchmark have been shown to have created real access problems for Medicare beneficiaries. These Medicare rates (and problems) should not be transferred to Medicaid beneficiaries. A study of the impact of the Medicare DME Competitive Bid Program on Medicare beneficiary access was conducted in 2017 by the Washington, DC firm Dobson DaVanzo and Associates. The study indicated 52% of Medicare beneficiaries reported trouble in obtaining DME. In addition, 77% of the discharge planners surveyed reported difficulties in discharging Medicare beneficiaries who required DME. This information is a warning of what will result should the Medicare rates be adopted on a state Medicaid level.

5.) Any Medicaid payment cuts to CRT will have a particularly negative impact on enrolled children and adults with significant disabilities and chronic medical conditions. This population is at substantial risk for medical complications and major health care expenses. There already is a fragile and limited network of qualified CRT suppliers. As explained in more detail in the next point, any payment cuts to these specialized products will reduce or eliminate access.

6.) Of the 255 DME codes identified as effected by the LFFP, 37 codes relate to CRT products. The following are important CRT facts that CMS and state policy makers must consider in an evaluation of adequate access to CRT for children and adults with significant disabilities and chronic medical conditions:

a. Complex Rehab Technology products and services are significantly different than standard Durable Medical Equipment- The DME benefit was created over fifty years ago to address the medical equipment needs of elderly individuals. Over the years CRT products have been developed for the unique needs of people with disabilities offering more features, function, and durability. Increasingly CMS has grouped these products into single HCPCS codes with vague descriptors. As a result, CRT items with a broad array of features/functions/durability and standard DME items are grouped into a single HCPCS code with only one level of reimbursement.
b. These specialized products are used by a small population of children and adults who have significant disabilities and chronic medical conditions- Individuals who require CRT have a complex disability or medical condition such as, but not limited to, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, Spinal Cord Injury, Amyotrophic Lateral Sclerosis, Spina Bifida, or Traumatic Brain Injury. CRT enables these individuals to deal with their daily physical, functional, and cognitive challenges. It plays a critical role in addressing the complex medical needs of these children and adults and in keeping them active and functional within their homes and communities. CRT also keeps health care costs down by reducing medical complications, clinical interventions, hospitalizations, institutionalizations, and caregiver needs.
c. The process of providing CRT products is done through a clinical model and is service-intensive (like the provision of custom Orthotics and Prosthetics)- The provision of CRT is typically done through an interdisciplinary team consisting of, at a minimum, a Physician, an independent Physical Therapist or Occupational Therapist, and a credentialed Assistive Technology Professional (ATP). The ATP is employed at a company accredited as a CRT supplier by a CMS approved accreditation organization. The team collectively provides clinical services and technology-related services designed to meet the specific and unique medical and functional needs of the individual. The activities of the CRT supplier are labor-intensive and include evaluating, recommending, securing funding, purchasing, assembling, delivering, fitting, adjusting, and training. The supplier is also responsible for ongoing modifications and repairs.
d. Due to significant operating costs and low profit margins there are only a small number of qualified CRT suppliers that supply these specialized products and services- This is a difficult business as companies providing CRT products must maintain the required trained and credentialed staff, supporting systems and facilities, and related company accreditations to perform the necessary activities. It is important to note that the evaluation and delivery process is service-intensive, and suppliers do not receive any separate payment to cover these costs. Supplying CRT comes with significant operating challenges and costs, along with low profit margins. As a result, there are a very limited number of companies that provide CRT and that number is decreasing across the country. An analysis of Medicare CRT providers from 2011 to 2014 showed a 40% decline.
e. Congress and CMS have recognized the specialized nature of CRT and it has been excluded from the Medicare Competitive Bid Program since its commencement in 2008- Given the unique nature of individually configured CRT products, these items have been specifically

excluded from inclusion in Medicare's Competitive Bid program. Accordingly, for certain DME wheelchair accessory codes the Medicare fee schedule has a different payment rate when an item is provided on a CRT wheelchair identified by a "KU" modifier.

Recommendations

Continuing to move forward with the implementation of the LFFP provision without addressing the issues and deficiencies raised above is contrary to the original intent of Congress. It would put Medicaid beneficiaries at significant risk of harm from a loss of access to critical equipment and supporting services. The negative consequences of an "improper" implementation will also increase overall state health care costs.

1.) To prevent significant negative outcomes for Medicaid beneficiaries and to avoid increased Medicaid health care costs for the states, we recommend the implementation of this "Limit on Federal Financial Participation" provision be delayed until 120 days after the following are completed:

   a. CMS should perform and publish the access study required per the Consolidated Appropriations Act of 2016 to fully evaluate the impact of applying Medicare DME payment rates to the Medicaid program.

   b. CMS should assemble and distribute a complete "information package" that includes all the relevant information (statute language, Medicaid Director instructions, specific impacted DME codes, analysis system, state compliance options, etc.) to provide a state with all the information needed to fully evaluate the impact of this provision.

2.) Once the above items are completed and made public, a state should be given 120 days to decide on its plans and report that decision to CMS.

Additional Information

NCART has a sincere desire to collaborate with CMS to produce the best outcomes for state Medicaid programs and for the enrolled beneficiaries with significant disabilities and chronic medical conditions.

We are happy to provide additional information as needed and would be happy to discuss our comments further via telephone or in person.

Sincerely,

Don Clayback

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