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May 8, 2023

RE: AN ACT to amend the social services law, in relation to providing parity to durable medical equipment providers by requiring Medicaid managed care organizations to reimburse such providers at no less than one hundred percent of the medical assistance durable medical equipment and complex rehabilitation technology fee schedule for the same services or item.

A.3408 (McDonald)
S.3468 (Rivera)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shields Plans opposes enactment of this bill, which would establish a permanent, minimum reimbursement level for durable medical equipment ("DME") and for individually configured, complex rehabilitation technologies ("CRT") under Medicaid Managed Care. The goal of this bill is to increase reimbursement under the Medicaid program for individually configured devices and mandate the payment of such increased reimbursement rates, without the ability to negotiate, under the managed care program. This bill would require premium rates for managed care organizations to be increased in order to assure the actuarial soundness of rates and account for the increased costs that must be paid for devices as a result of this bill.

In the absence of a premium increase for managed care plans, this legislation would negatively impact the financial viability of many managed care plans. In authorizing the Department of Health ("DOH") to set a "benchmark" rate that managed care plans would be required to pay for a particular Medicaid service or product indefinitely, this legislation will undoubtedly increase the reimbursement rate for these products and require managed care plans to bear this cost. More importantly, this language deviates from previous DOH practice in relation to setting benchmark rates for products or services under Medicaid Managed Care. In instances where DOH has set a fee-for-service rate as the benchmark rate for a new product or service being carved-in to managed care, it has always been accompanied with an expiration date for the purpose of encouraging plans and providers to negotiate an appropriate reimbursement rate. By not containing an expiration

date on the use of the benchmark rate, this legislation provides no incentive to suppliers to contract at a lower rate with managed care plans.

Furthermore, New York does not currently have a complex rehabilitation technology fee schedule, yet this bill would require managed care plans to adopt a fee schedule that does not currently exist, thus requiring New York to establish separate billing codes for CRT to comply with this bill. As with prior versions of this bill, all of which have been vetoed, the underlying purpose is to establish separate billing codes for CRT. As proponents of the bill are making a nationwide push to create separate billing codes under Medicare for CRT, this bill will ultimately increase costs incurred by the State and require adjustments for managed care premiums if changes are made to the Medicare program.

The coverage changes sought by this bill by establishing a CRT fee schedule extend far beyond existing coverage guidelines for rehabilitative equipment, raise questions regarding the need for increased costs due to the "customized" nature of these products. This bill purports to provide vulnerable New Yorkers with access to complex rehabilitation technologies that would not otherwise be available to them. However, the complex technologies, are already covered under Medicaid. Thus, despite assertions otherwise, as the State's primary and largest insurer of persons with disabilities, Medicaid provides comprehensive coverage of an assortment of complex devices and "technologies", and, in those rare instances where standard devices cannot meet the individual's needs, the State allows customizations, including the ability to receive a unique, custom-built piece of equipment.

Medicaid and Medicare extensively cover the DME and CRT referenced in this bill. In fact, they allow for individuals to obtain individually customized equipment when standard devices cannot meet the individual's needs. However, individually configured devises are seldom covered, not just because of their prohibitive expense, but because they are <u>hardly ever medically necessary</u> given the abundance of standard alternatives that are available to meet an individual's needs.

Importantly, Medicare guidelines evidence that the sort of individual configurations and adaptations this bill would attempt to increase Medicaid reimbursement for do not receive special reimbursement treatment under Medicare currently, meaning it would be up to the State to fund this cost entirely. Specifically, Medicare does not consider items that are measured, fitted or adopted to a patient's individual body profile or need to meet the definition of "customized items" and do not require separate reimbursement and billing codes.

Indeed, these concerns are completely ignored as this legislation is part of a larger, national CRT supplier movement that is focused solely on expanding Medicaid and Medicare coverage for customized technologies. Similar to New York, Medicare rarely reimburses for "customized items", providing through coverage criteria guidance that these items are "so rarely necessary" and "rarely furnished" that "wheelchair-confined, conjoined twins facing each other" is the standard for when customized DME would actually be covered. Yet, this bill would seek to impose this mandate on New York.

At its core, this bill is seeking to establish higher, reimbursement rates for certain "customized"

equipment by providing that DOH will set benchmark rates for "customized" equipment. However, it is clear that the "customization" that the State would be paying for is merely standard devices, which are already covered, but measured, fitted or adopted to a patient's individual body profile or need. Medicare has already determined that this type of modification is not truly "custom" and does not require separate reimbursement and billing codes. This legislation would greatly increase Medicaid spending in New York to the direct benefit of medical device suppliers and is unnecessary in light of the fact that the "customization" the State is paying does not necessitate increased reimbursement.

For the foregoing reasons, the Blue Cross and Blue Shield Plans urge that this bill not be enacted.

Respectfully submitted,

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Legislative Counsel for the Blue Cross and Blue Shield Plans

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