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RE: AN ACT to amend the social services law, in relation to coverage and billing procedures in the Medicaid program for complex rehabilitation technology for patients with complex medical needs.

A.4232 (Steck)
S.3433 (Skoufis)

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 increase Medicaid reimbursement for individually configured, complex rehabilitation technologies ("CRT") and dramatically expand coverage for these devices under Medicaid and Medicaid Managed Care. The goal of this bill is to increase reimbursement under the Medicaid program for individually configured devices, and require the payment of such reimbursement rates under the Managed Care program. This bill would require premium rates for Managed Care Organizations ("MCOs") to be increased in order to ensure the actuarial soundness of rates and account for the increased costs that must be paid for such devices as a result of its terms.

As explained below, the coverage changes sought by this bill extend far beyond existing Federal coverage guidelines for rehabilitative equipment, bringing into question the need for increased costs due to the "customized" nature of these products. Furthermore, it would restrict the ability of the State to manage the Medicaid program, as it requires New York to immediately incorporate new billing codes created at the federal level for CRT under Medicare for use by New York's Medicaid program. As proponents of the bill are making a nationwide push to create separate billing codes under Medicare for CRT, this bill would ultimately increase costs incurred by the State and require adjustments for managed care premiums if changes are made to the Medicare program.

In the absence of a premium increase for MCOs, this legislation would negatively impact the financial viability of many managed care plans. In authorizing 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 Department of Health ("DOH") practices relating to the establishment of benchmark rates for products or services under Medicaid Managed Care. In instances where the DOH has set the 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 including 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.

1. **MEDICAID ALREADY COVER THE DEVICES MANDATED BY THIS BILL.**

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 described in this legislation - including gait trainers, manual and motorized wheelchairs, and an extensive variety of accessories and components - are already covered under Medicaid. Thus, despite assertions to the contrary, as the State's primary and largest insurer of persons with disabilities, Medicaid provides comprehensive coverage of an assortment of complex devices and technologies, including those addressed in this bill; and, in those rare instances where standard devices cannot meet the individual's needs, the State allows accommodations, including the ability to receive a unique, custom-built piece of equipment.

New York Medicaid's Durable Medical Equipment ("DME"), Prosthetics, Orthotics, and Supplies policy manual provides detailed and comprehensive coverage guidelines and procedure codes for such reimbursable devices and accessories. Gait trainers are covered, as are "wheeled mobility equipment" - or manual wheelchairs and power wheelchairs. Specific coverage guidelines for powered mobility devices include an extensive array of options and accessories to ensure that the needs of all Medicaid beneficiaries are met. This includes a special billing code (e.g. K009) designed to allow Medicaid recipients to receive a custom-made wheelchair, defined as "a wheelchair frame that is uniquely constructed or substantially modified for a specific beneficiary," provided that the "the feature needed is not available in an already manufactured wheelchair or accessory."

2. **THIS BILL SEEKS TO ESTABLISH HIGHER REIMBURSEMENT RATES FOR DEVICES THAT ARE ALREADY COVERED UNDER THE GUISE THAT THEY NEED TO BE "CUSTOMIZED"**

Medicaid and Medicare extensively cover the medical equipment contained in this bill. In fact, they allow for individuals to obtain individually customized equipment when standard devices do not meet an individual's needs. However, individually configured devises are seldom covered not only because of their prohibitive expense, but because they are hardly ever medically necessary 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 does not require separate reimbursement and billing codes.[1]

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 practices, 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.[2] 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 the 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 that are already covered, but measured, fitted or adapted 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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1 "Items that are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items) or have been assembled by a supplier or ordered from a manufacturer who makes available customized features, modification or components for wheelchairs that are intended for an individual patient's use with instructions from the patient's physician do not meet the definition of customized items. These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes. The use of customized options or accessories or custom fitting of certain parts does not result in a wheelchair or other equipment being considered as customized." Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), "30.3 - Certain Customized Items" P.18, *available at* http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf

2 *Id.*