COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 31, 2022

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance and Appropriations Committee

The Honorable L. Louise Lucas
Chair, Senate Education and Health Committee

The Honorable Barry D. Knight
Chair, House Appropriations Committee

The Honorable Robert D. Orrock
Chair, House Health, Welfare and Institutions Committee

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Chapter 476 (HB241) – Coverage of Complex Rehabilitative Technology for Nursing Facility Members through the Durable Medical Equipment Program

This report is submitted in compliance with the Chapter 476 (HB241) of the 2022 General Assembly Session, which states:

> *Directs the Department of Medical Assistance Services to convene a work group with the Department of Planning and Budget and other relevant stakeholders to study the overall cost of and options for the provision of medical assistance to cover and reimburse complex rehabilitation technology (CRT) manual and power wheelchair bases and related accessories for qualified individuals who reside in nursing facilities. The bill requires the work group to report its findings to the Chairmen of the Senate Committees on Finance and Appropriations and Education and Health and the House Committees on Appropriations and Health, Welfare and Institutions by September 15, 2022.*

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CR
Enclosure

Pc: The Honorable John Littel, Secretary of Health and Human Resources

Coverage of Complex Rehabilitative Technology (CRT) for Nursing Facility (NF) Members through the Durable Medical Equipment (DME) Program

A Report to the Virginia General Assembly — *October 31, 2022*

Report Mandate:

Chapter 476 (HB241) Directs the Department of Medical Assistance Services to convene a work group with the Department of Planning and Budget and other relevant stakeholders to study the overall cost of and options for the provision of medical assistance to cover and reimburse complex rehabilitation technology (CRT) manual and power wheelchair bases and related accessories for qualified individuals who reside in nursing facilities. The bill requires the work group to report its findings to the Chairmen of the Senate Committees on Finance and Appropriations and Education and Health and the House Committees on Appropriations and Health, Welfare and Institutions by September 15, 2022.

Overview

Medicaid currently reimburses Nursing Facilities (NF) a per diem that covers care for Medicaid members enrolled in a NF. The majority of the member's durable medical equipment (DME) needs must be provided by the facility under this per diem. There are a few exceptions to this rule due to the high costs associated with certain types of equipment which is sometimes referred to as Complex Rehabilitative Technology (CRT). Because CRT is expensive, the NF is not required to pay for these items and can use the member's patient pay to cover these costs. Patient pay refers to the member's obligation to pay towards the cost of long-term care if the member's income exceeds certain thresholds. The patient pay amount is determined by the Local Departments of Social Services (LDSS)

Currently, only the costs associated with medically necessary, individual-specific, customized, or non-covered items or services may be deducted from patient pay. Specifically, these include electric, motorized, or customized wheelchairs and other equipment not regularly supplied to individuals as part of the cost of care. Supplies, equipment, or services used in the direct care and treatment of individuals are covered services and must be provided by the NF. These may include, but are not limited to, standard wheelchairs, recliners, geriatric chairs, special mattresses, humidifiers, cots, incontinent supplies, and routine podiatry care. The NF is responsible for providing these items/services to individuals and their costs cannot be deducted from patient pay.

The patient pay adjustment process is limited to those Medicaid members who have a patient pay amount. Medicaid uses the patient pay amount to determine the amount of the NF's monthly expenses that the patient will pay. The LDSS determines the patient pay amount; however, not all Medicaid members have a patient pay responsibility.

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.

When appropriate to pay for CRT, the member's patient pay goes to the DME provider, not the NF, to pay for the equipment. The DME provider can choose to accept the patient pay and recoup the cost of the item via the patient pay each month until the item has been paid in full, which can sometimes take years to be fully reimbursed. Therefore, many DME providers are not willing to accept this payment method.

As a result of a member either a) not having patient pay, or b) the DME provider being unwilling to accept the patient pay amount, some NF members have been unable to obtain needed equipment. Accordingly, HB 241 was drafted with the intention of providing a means for members residing in NFs to obtain CRT by allowing DME providers to bill directly for the items instead of using the patient pay adjustment process.

Adding coverage of CRT for NF members through the DME program will ensure the mobility needs of those who have complex medical conditions are met, allowing members to maintain a higher level of independence and access to the same equipment available to those in the community. CRTs have also been shown to increase continuity of care and prevent complications like bedsores or falls.

In compliance with HB 241 and to address the above-discussed issues, stakeholders met on July 21, 2022 and were represented by: Virginia Healthcare Association-Virginia Center for Assisted Living (VHCA-VCAL), Leading Age, United Spinal Association, American Association of Homecare, Virginia Association of Health Plans (VAHP), DME providers, Managed Care Organizations (MCOs), and DMAS.

CRT for Nursing Home Residents in Other State Medicaid Agencies

DMAS conducted a review of six peer[1] state Medicaid agency policies regarding CRT for members residing in a NF. All six states currently cover power wheelchairs or custom wheelchairs for members in a NF outside of the nursing home per diem.

Nursing Facility Usage vs. Community Usage

To better understand the current need for CRT in Virginia's NFs, a questionnaire was distributed which asked each facility several questions regarding their current experience and needs. DMAS received 33 responses to that survey. Based on the results, 37 members in the last year were reportedly unable to get a custom wheelchair because they either a) did not have patient pay, b) did not meet criteria, or c) the DME provider would not accept the patient pay amount(s). In addition, the survey identified 94 members who were admitted to NFs with their own custom wheelchair, leaving an estimated 35-50[2] members currently in need of a custom wheelchair.

DMAS also conducted a data analysis to better understand the current usage of CRT for Medicaid members *not* residing in NFs. Lastly, DMAS, in conjunction with the Department of Planning and Budget (DPB), reviewed data from the current community usage and NF survey to determine cost estimates for the proposal, detailed below.

Findings

The workgroup identified three main areas that would need to be addressed in order to develop an accurate cost estimate. The group identified the need to a) define CRT; b) clearly delineate the targeted population within the nursing facilities, who need CRT; and c) establish a set of manual and power wheelchair base codes to be included within the definition of CRT.

Proposed Bill Language

Should the Governor and General Assembly decide to provide Medicaid coverage of CRT in a subsequent Session, the following could be used as bill language. Additionally, DMAS also recommends that no reimbursement limits be placed in this

[1] Review of peer states included Wisconsin, Washington State, Vermont, Massachusetts, Michigan, and Missouri. Survey results are available upon request.

[2] One nursing stated they had 23 members who are in need of a custom wheelchair. This response is abnormally high and will require follow-up better understand the discrepancy. Because of this discrepancy a range was used for the results.

proposed language to comply with CMS' prohibition of limits within the DME program:

State plan for medical assistance services; DME & CRT Requirements. *DMAS must include in the state plan for medical assistance services a provision for payment of medical assistance for the initial purchase or replacement of CRT manual and power wheelchair bases and related accessories, as defined by the agency's DME program policy, for patients who reside in NFs. Initial purchase or replacement is contingent upon a) determination of medical necessity; b) requirements in accordance with regulations established through the agency's DME program policy; and c) exclusive use by the NF member for whom it was ordered. Recipients of medical assistance shall not be required to pay any deductible, coinsurance, copayment or patient pay for medical assistance. The department shall have the authority to promulgate emergency regulations to implement these amendments within 280 days or less from the enactment of this Act, and is authorized to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.*

Proposed Definition of Complex Rehabilitative Technology

The stakeholder workgroup developed a proposed definition of CRT since there is no standard federal definition. If approved, the following definition will be a basis for the program.

Complex Rehabilitation Technology– Defined as wheelchairs and other seating systems classified as medical equipment within the Medicaid program that:

1. Are customized and individually configured for individuals to meet their specific and unique medical, physical, and functional needs including basic activities of daily living, as determined to be medically necessary.

2. Are primarily used to a) serve a medical purpose and are generally not useful to an individual in the absence of an illness or injury; b) maximize an individual's function and independence; and c) are subject to medical necessity review and approval and not provided solely for caregiver convenience.

3. Require certain services necessary for appropriate design, configuration, and use of such items, including individual evaluation, equipment fitting and configuration of the CRT wheelchair. The following standards for a CRT evaluation included:

- The evaluation is performed by a licensed physical or occupational therapist not directly employed by the DME provider or the NF in which the member resides.
- The evaluation is done in conjunction with an assessment by, at a minimum, one Assistive Technology Professional (ATP) or Rehabilitation Engineering Technologist (RET) who is employed by the DME provider to analyze the needs and capacities and provide training in the use of the selected covered CRT items. The ATP or RET must be certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
- The ATP or RET must be physically present for the evaluation and determination of the appropriate individually configured CRT for the complex-needs member.

CRT is designed to meet the specific and unique medical and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma. The workgroup proposed the following list of diagnoses to better define the need of those individuals who might need a CRT wheelchair which, in turn, informed DMAS in developing the cost estimates, provided below.

- Spinal cord injury
- Anterior horn cell diseases
- Brain injury
- Post-Polio Syndrome
- Cerebral Palsy
- Cerebellar degeneration
- Muscular Dystrophy
- Dystonia
- Spina Bifida
- Huntington's disease
- Osteogenesis Imperfecta
- Myopathy
- Progressive Muscular Atrophy
- Spinocerebellar disease
- Arthrogryposis
- Certain types of amputation

- Amyotrophic Lateral Sclerosis
- Paralysis or paresis
- Multiple Sclerosis
- Demyelinating Diseases
- Myelopathy; or
- Other disabilities or disease that is determined through individual consideration to require the use of such individually configured products and services.

Wheelchair Codes Included under CRT

Based on the workgroup's review of other states' programs and following discussion with providers, the DME subject matter experts on the workgroup identified the most appropriate manual and power wheelchair codes to be included under the definition of CRT. The following manual and power wheelchair base codes are recommended in order to more accurately establish cost estimates:

- K0835-K0843 Group 2 Power Chairs
- K0848-K0864 Group 3 Power Chairs
- K0868-K0871 and K0877-K0886 Group 4 Power Chairs
- K0005, E1161 Manual Chairs (E1231-E1238 are Pediatric Manual Chairs)
- E0986 push-rim activated power assist option for a manual wheelchair

Proposed Cost Estimate

Calendar year 2021 claims using applicable wheelchair procedure codes were summarized by primary diagnosis code in order to determine the top 20 reimbursed diagnosis codes based on payment amount. The data was then summarized by member for any claims that reported one of these 20 diagnosis codes, allowing for the calculation of the average total reimbursement of these services per member.

A survey requesting information about the need of these wheelchairs was distributed to nursing facilities. A total payment amount per facility for these services was calculated using the number of residents reported to be in need of a wheelchair and the number of nursing facilities that responded to the survey. This payment amount per facility was then applied to the total number of nursing facilities that provide services under Virginia Medicaid, resulting in the total fiscal impact of implementing these services.

It was assumed that all nursing facilities that provide services under Virginia Medicaid will have the same need for these new services as the small number of facilities that responded to the survey.

Average of Total Cost per Member	$	6,884.46
Residents in Need of a Wheelchair (per survey)		50
Total Cost of Wheelchairs	**$**	**344,223.00**
Number of Nursing Facilities (per survey)		33
Cost per Facility	**$**	**10,431.00**
Total Number of Nursing Facilities		250
Fiscal Impact	**$**	**2,607,750.03**