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BILL ANALYSIS

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Senate Bill 855 (as introduced 4-16-20)
Sponsor: Senator Kevin Daley
Committee: Health Policy and Human Services

Date Completed: 6-22-20

CONTENT

The bill would enact the "Complex Needs Patient Act" to require the Department of Health and Human Services (DHHS) to establish focused policies and promulgate focused rules that met certain requirements for complex rehabilitation technology products and services.

Definitions

Under the bill, "complex needs patient" would mean an individual with a diagnosis of a medical condition that results in significant physical impairment or functional limitation. Complex needs patient includes an individual with spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteogenesis imperfecta, arthrogryposis, amyotrophic lateral sclerosis, multiple sclerosis, demyelinating disease, cell disease, post-polio syndrome, cerebellar degeneration, dystonia, Huntington's disease, spinocerebellar disease, and certain types of amputation, paralysis, or paresis that result in significant physical impairment or functional limitation. A complex needs patient would have to meet medical necessity requirements to qualify for receiving complex rehabilitation technology.

"Complex rehabilitation technology" would mean an item classified within the Medicare program as of January 1, 2019, as durable medical equipment that is individually configured for an individual to meet his or her specific and unique medical, physical, and functional needs and capacity for basic activities of daily living and instrumental activities of daily living identified as medically necessary. The term would include complex rehabilitation manual and power wheelchairs and options or accessories, and other specialized equipment such as standing frames and gait trainers and options or accessories.

"Healthcare common procedure coding system" (HCPCS) would mean the billing codes used by Medicare and overseen by the Federal Centers for Medicare and Medicaid Services that are based on the current procedural technology codes developed by the American Medical Association.

"Individually configured" would mean a device has a combination of sizes, features, adjustments, or modifications that a qualified complex rehabilitation technology supplier can customize to a specific individual by measuring, fitting, programming, adjusting, or adapting the device as appropriate so that the device is consistent with an assessment or evaluation of the individual by a qualified health care professional and consistent with the individual's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

"Qualified health care professional" would mean a health care professional licensed by the Department of Licensing and Regulatory Affairs (LARA) who has no financial relationship with a qualified complex rehabilitation supplier. If a qualified complex rehabilitation technology supplier was owned by a hospital, the health care professional could be employed by the hospital and work in an inpatient or outpatient setting. The term would include a licensed physician, a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who performed specialty evaluations within the professional's scope of practice.

"Qualified complex rehabilitation technology professional" would mean an individual who is certified as an assistive technology professional by the Rehabilitation Engineering and Assistive Technology Society of North America or as a certified complex rehabilitation technology supplier by the National Registry of Rehabilitation Technology Suppliers.

"Qualified complex rehabilitation technology supplier" would mean a company or entity that is or does all the following:

-- Is accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology.
-- Is an enrolled Medicare supplier and meets the supplier and quality standards established for durable medical equipment suppliers, including the standards for complex rehabilitation technology, under the Medicare program.
-- Requires a qualified complex rehabilitation technology professional be physically present for the evaluation and determination of appropriate complex rehabilitation technology.
-- Has the capability to provide service and repair by a qualified technician for all complex rehabilitation technology it sells.
-- Provides written information at the time of delivery of complex rehabilitation technology regarding how the complex needs patient may receive service and repair.

In addition to the requirements above, a qualified complex rehabilitation technology supplier would have to employ as a W-2 employee, at least, one qualified complex rehabilitation technology professional for each location to do the following: a) analyze the needs and capacities of the complex needs patient in consultation with qualified health care professionals; b) participate in the selection of appropriate complex rehabilitation technology or the needs and capacities of the complex needs patient; and c) provide technology-related training in the proper use of the complex rehabilitation technology.

Complex Rehabilitation Technology Policy and Rules

Under the bill, the DHHS would have to establish focused policies and promulgate focused rules for complex rehabilitation technology products and services. The policies and rules would have to take into consideration the individually configured nature of complex rehabilitation technology and the broad range of services necessary to meet unique medical and functional needs of an individual with complex medical needs by doing all the following:

-- Designating specific HCPCS billing codes for complex rehabilitation technology and any new codes in the future as appropriate.
-- Establishing specific supplier standards for a company or entity that provided complex rehabilitation technology and restricting providing complex rehabilitation technology to only a qualified complex rehabilitation technology supplier.
-- Requiring a complex needs patient receiving a complex rehabilitation manual wheelchair, power wheelchair, or seating component to be evaluated by a qualified health care professional and a qualified complex rehabilitation technology professional.

-- Exempting the related complex rehabilitation technology HCPCS billing codes from inclusion in bidding, selective contracting, or similar initiative.
-- Requiring that managed care Medicaid plans adopt the regulations and policies outlined in the bill and contract with a willing, qualified complex rehabilitation technology supplier.
-- Making other changes as needed to protect access to complex rehabilitation technology for complex needs patients.

In addition, the focused policies and rules would have to take into consideration the individually configured nature of complex rehabilitation technology and the broad range of services necessary to meet unique medical and functional needs of an individual with complex medical needs by maintaining payment policies and rates for complex rehabilitation technology to ensure payment amounts were adequate to provide complex needs patients with access to those items. These policies and rates would have to take into account the significant resources, infrastructure, and staff needed to appropriately provide complex rehabilitation technology to meet the unique needs of a complex needs patient.

Legislative Analyst: Stephen Jackson

FISCAL IMPACT

The bill would have a minimal fiscal impact. The bill would create recognition of what is commonly referred to as complex rehabilitation technology as a separate category in the State's Medicaid program. This new category would include specialized, often individualized (to meet individual needs) equipment for a subset of disabled Medicaid clients whose equipment needs are presently provided through the durable medical equipment benefit in Medicaid. There could be potential greater specific equipment costs for this relatively small segment, but these costs could be more than offset by reduced costs due to improved health outcomes for individuals whose needs were served better by more appropriate equipment. Because of the relatively narrow coverage group, any costs or savings would be minor relative to overall Medicaid costs.

Fiscal Analyst: Steve Angelotti

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