Medicaid: A Look at AT Reuse in Current Programs

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AMAC Accessibility

AMAC Accessibility is a social change organization on a mission to create affordable services for governmental, private, and nonprofit organizations working with individuals with disabilities.

Services include E-text, Braille, live captioning, assistive technology, disability office management software, and accessibility consulting.

Tools for Life (TFL)

TFL, Georgia's AT Act Program, helps Georgians of all ages and disabilities gain access to and acquire assistive technology devices and services so they can live, learn, work, and play independently in the communities of their choice.

Framing a National Discussion: AT Reuse

This session will explore a topic of potential national significance: the reuse of assistive technology, specifically that subset known as “durable medical equipment” or DME, in the Medicaid program.

In three states, Medicaid partners with a State AT Act Program on a broad scale in the reutilization of DME.

Why?

How?

Who benefits?

What is Medicaid?

Medicaid is a public health insurance program operated by states within broad federal guidelines (and supported by a combination of state and federal taxes).

The federal budget share is determined by several different formulas, depending on the program component.

33 states have used Medicaid programs to expand health insurance coverage to the uninsured under the Affordable Care Act.

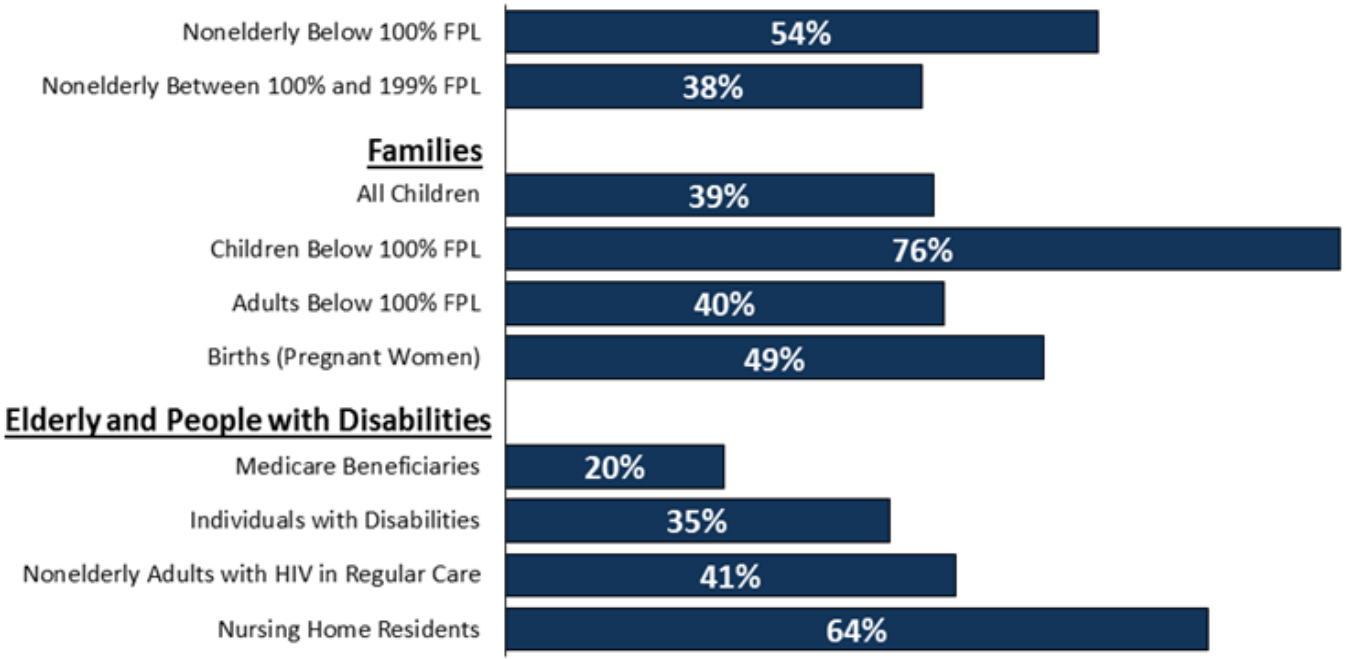
Social Security Amendments of 1965 (P.L. 89-97)
*Kaiser Family Foundation. *Medicaid: Moving Ahead in Uncertain Times, Oct. 19, 2017.*

Beneficiaries

Figure 1

Medicaid's Role for Selected Populations

Percent with Medicaid Coverage



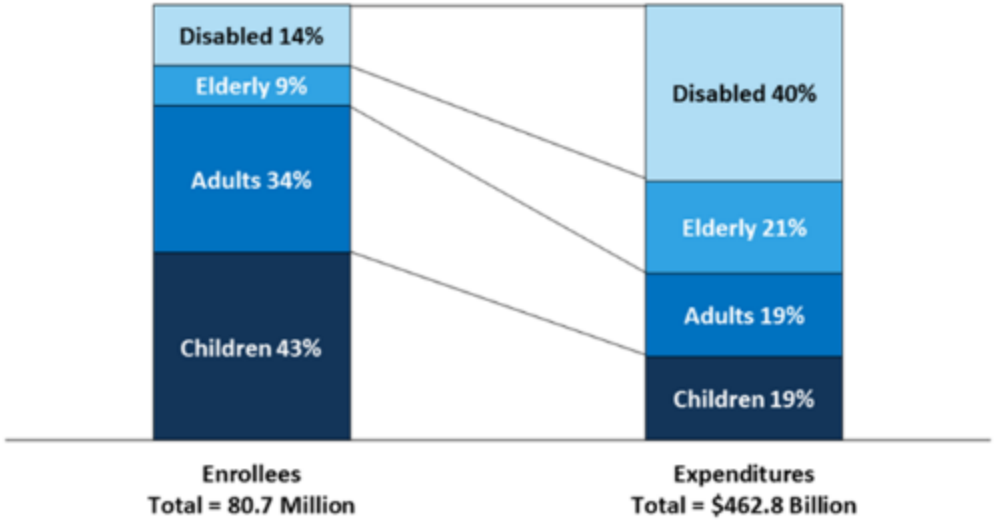
NOTE: FPL-- Federal Poverty Level. The FPL was $20,160 for a family of three in 2016.

SOURCES: Kaiser Commission on Medicaid and the Uninsured (KCMU) analysis of 2016 CPS/ASEC Supplement; Birth data - Kaiser Family Foundation Medicaid Budget Survey, 2016 (median rate shown); Medicare data - Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (January 2016), 2011 data; Disabilities - KCMU Analysis of 2015 NHIS data; Nonelderly with HIV - 2009 CDC MMP; Nursing Home Residents - 2012 OSCAR data.

What does Medicaid funding support?

Figure 1

Nearly two-thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.



NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.

How big is Medicaid?

- Third largest item in U.S. domestic budget (after Social Security and Medicare)
- Second largest item in state budgets (after elementary and secondary education)
- Nation’s largest single health insurer
- Covers 79 million Americans (1 in 5)
- Pays for 20% of all U.S. healthcare spending

Factors Driving Interest in Reuse

- Unemployment levels and the weak economy added to the number of uninsured and made increasing numbers eligible.
- Implementation of the Affordable Care Act was used to expand medical coverage under Medicaid in 33 states.
- All healthcare costs are growing, and DME is a major cost. A manufacturer study (several years ago) found that ***28% of wheeled mobility equipment and seating was paid by Medicaid***.

How much does Medicaid spend on DME?

The total Medicaid budget (state and federal combined) for FY 2016 was $574 billion.*

In Medicaid, equipment and appliances covered under the home health services or physical, occupational, and speech/language therapy encompass the items considered to be DME. While not reported as a separate category, **an estimated 1%, or more than $5 billion, was spent on DME.****

*Includes administrative costs, accounting adjustments, and U.S. Territories.
https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/

It cuts both ways: Those huge Medicaid expenses also contribute to the economy.

Medicaid funding is a major source of support for hospitals and doctors, nursing homes, and jobs in the healthcare sector.

Today's Learning Objectives

We want to introduce you to successful Medicaid partnerships with AT reuse programs. Afterward, you should be able to:

- **Objective 1:** Describe three successful models of AT reuse in Medicaid, and how these programs aid populations with AT needs for employment support and other activities.
- **Objective 2:** Explain how reusing durable medical equipment helps contain Medicaid costs and meets the needs of persons with disabilities and the aging population.
- **Objective 3:** Identify four societal issues related to the incorporation of lightly used devices into the tax-supported healthcare system.

For more information, please visit the Pass It On Center website at www.passitoncenter.org

Brief History of AT Reuse

Reuse is not new. Churches, nonprofit organizations, and support groups have hosted "loan closets" of AT for decades. One nonprofit, the Convalescent Aid Society of Pasadena, CA, opened in 1923 and is still going strong. A number of major reuse programs started in basements or garages.

Some recent milestones for AT reuse include:

1994: Changes to the Tech Act set the stage for public-private collaborations.

1999: The first national conference on AT reuse is held.

2000: RESNA TA program clarifies the difference between "reutilization" and "recycling".

2004: The Tech Act language identifies "AT reutilization" as a required activity.

2006: The U.S. Dept. of Education funds a National Technical Assistance Center for Reuse, the Pass It On Center, and 12 model reuse demonstration projects, to improve and expand reuse.

Reuse Must Be Safe, Effective, and Appropriate

Reuse is a Mandated Activity for the 56 AT Act Programs

[Association of Assitive Technology Act Programs – www.ataporg.org](http://www.ataporg.org)

Reuse Grows with Federal Support

Pass It On Center and the demonstration projects build resources, provide TA and education, and devise Indicators of Quality for AT Reuse. Key activities:

2009: Pass It On Center hosts national AT Reuse Conference in Atlanta

2010: First National Emergency Management and AT Reuse Summit held in DC

2011: First FEMA Region EM & AT Reuse Summit

2012: - Oklahoma Medicaid Partnership Launched
- PIOC Webinar on Medicaid Partnerships
- National Summit on Reuse with ILCs

2015: Pass It On Center Releases Medicaid Guide

2016: South Dakota Medicaid Partnership Starts

Hurricane Katrina floods New Orleans, 2005, resulting in tragedies and lessons learned about emergency response for people with disabilities. PIOC now plays a key role.

AT reuse benefits many

We know that access to DME:

- Improves health and safety
- Minimizes doctor visits and returns to hospitals
- Reduces or delays assisted living and nursing home placements
- Enables some people to return to work

Outcomes Depend on Timely Availability

88.9% of case managers/discharge planners report an inability to obtain the products needed for their customers quickly.*

Reused devices may serve as an interim solution while the individual waits for the delivery of a new device.

*http://www.modernhealthcare.com/article/20171127/NEWS/171129942/

Medicaid and Reuse Programs

- **At least 21 states have considered DME reuse as part of the Medicaid program.**
- **PIOC has consulted with states about Medicaid and reuse in the past 10 years.**
- **Status today (as we know it):**
  - **Reuse programs with *some* Medicaid component: KS, DE, OK, SD, ID, VA, IN, VT**
  - **Investigating: MD**

Different Models for Involvement

- Medicaid pays for inventory tracking of all donated DME and the refurbishing of Medicaid-purchased devices that come into the reuse program. (Kansas, Oklahoma, South Dakota)
- Medicaid-purchased equipment may be stickered for return to a reuse program when no longer needed.
- Other states have programs with limited involvement.

An Overview of Three Successful AT Reuse Partnerships with Medicaid

2003 Kansas

2012 Oklahoma

2016 South Dakota

Kansas: The Demonstration Project with a Medicaid Partnership

- One of the 12 demonstration projects funded by the Dept. of Education in 2006 was the Kansas Equipment Exchange.*
- Starting in 2003, Kansas had a state-wide partnership with Medicaid, and became the model for such programs.
- Subsequent programs in Oklahoma (2012) and South Dakota (2016) were based on the Kansas model.

*Now KEE Reuse Program

Priorities for Reuse Programs

1. Retain consumer choice: Reused equipment should not be the first and only choice.
2. Foster safe and appropriate reuse: Match the beneficiary to the needed device, not “a device.”
3. Focus on reuse as an interim solution when delays occur, as a secondary device, or as a transition device.
4. Maintain a positive or at least neutral impact on the DME industry and providers.

Challenges for Partnerships

Administrative issues:

- Legal/compliance issues
- Accreditation (voluntary at present)
- Workplace safety
- Sanitization and consumer safety
- Equipment tracking for recalls and alerts

Challenges for Partnerships – Financial

Financial:

- How the program is funded
- Identifying which items or categories represent the most significant return on investment (ROI) for Medicaid
- Fraud prevention
- Reimbursement

Challenges for Partnerships - Users

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User Services:

- Matching customer to appropriate (or prescribed) device
- Compliance with state laws that require set-up of some devices by professionals with specific credentials (e.g., CPAP by respiratory therapist)
- Training in the use and cleaning of the device
- Follow-up
- Outcomes measurement

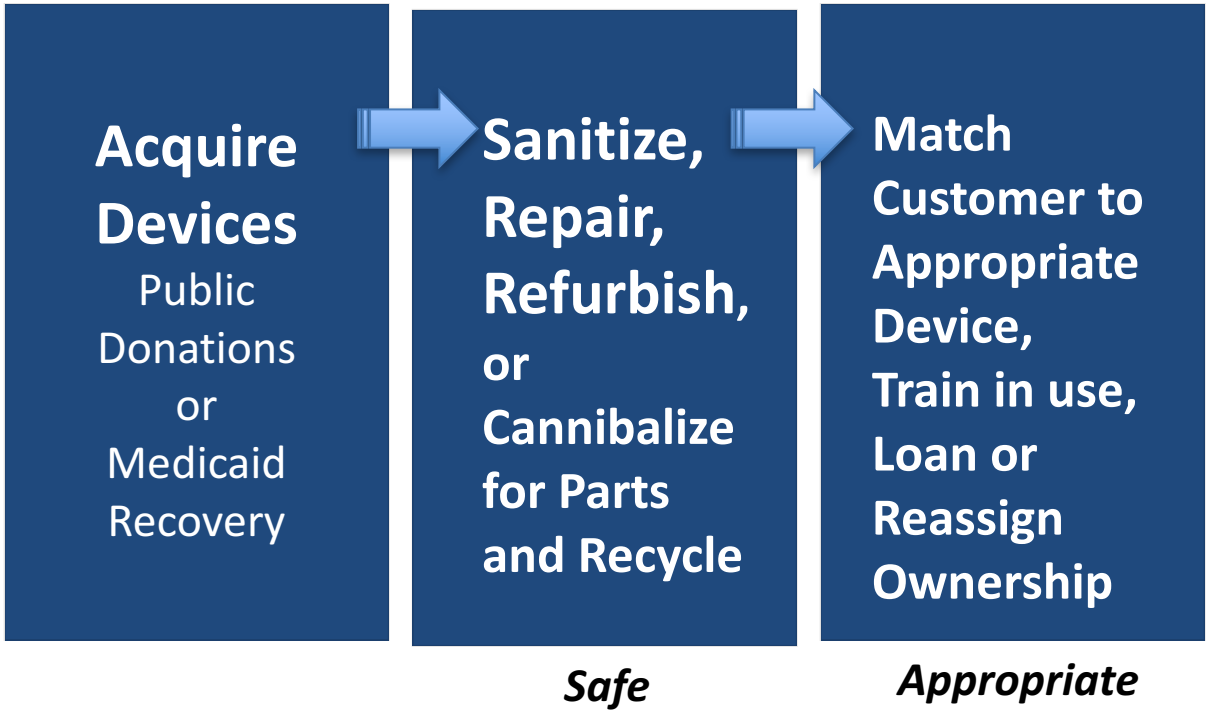
How does the Kansas model work?

- **The reuse program is a collaboration among:**
  - Kansas Medicaid
  - Durable medical equipment providers
  - Assistive Technology for Kansans (AT Act Program)
  - Consumers

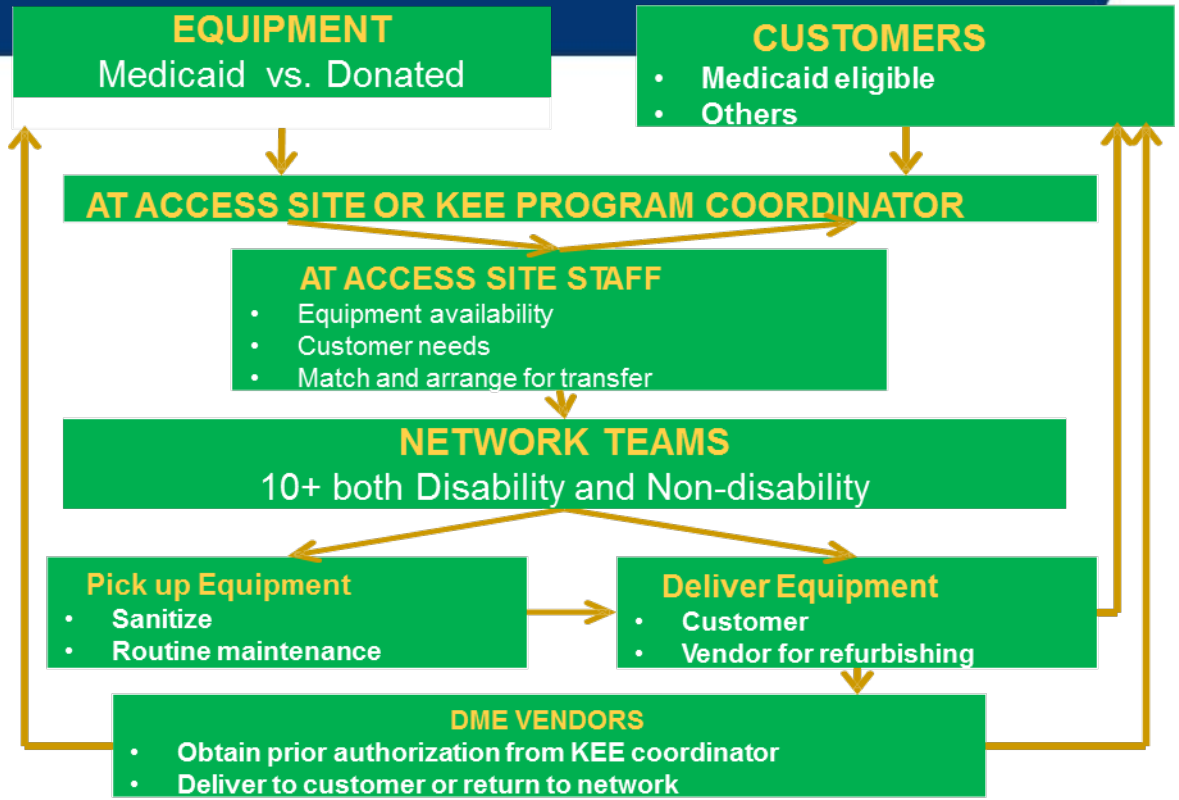
- **This collaboration is specified in contractual agreement.**

Device Reuse Process

Reuse programs try to recover Medicaid-purchased devices when no longer needed, and accept public donations of lightly-used DME.



Kansas Model



Kansas Organizing Factors

Track, recover, refurbish and reassign DME

- Focus on high cost, lightly used devices
- Non-DME AT is accepted and refurbished with funds from other sources

Focus on appropriateness and safety

- Refurbishing by trained technicians through commercial DME vendors
- Measures to ensure appropriate devices

Commonly Accepted Devices

- AAC devices
- Bath benches, shower chairs, commodes
- C-PAP devices
- Canes, crutches, walkers
- Feeder seats, feeding pumps
- Hospital beds
- Patient lifts
- Scooters, manual wheelchairs, power wheelchairs
- And more…

How Reuse Programs Get Inventory

Reclaiming Medicaid-purchased devices:

- Devices are stickered with requests to return when no longer needed.
- Device users are tracked in the database.
- Follow-up calls.

Public donations:

Active efforts to increase awareness of need and to encourage donations through

- Presentations
- Public service announcements
- Subcontractors
- Network teams (partners)

DME for Medicaid beneficiaries and others: Kansas model

- Medicaid may place a priority hold on an item in inventory
- Devices are maintained in inventory at KEE Reuse Program for 120 days
- Equipment not reassigned by KEE after 120 days is distributed to partner organizations throughout the state for reassignment to others in need

Kansas: How It Works

The reuse program is based at the University of Kansas, taking advantage of shared resources.

Partners and the public donate lightly used devices to the program.

Partners participate in distribution.

https://www.youtube.com/watch?v=P7APko-KoVc

Medicaid pays for:

- Maintenance of a database for inventory and tracking, and
- Repairs to devices (by certified technicians at DME providers) reassigned to Medicaid recipients

The reuse program pays for repairs to devices for non-Medicaid recipients.

Who partners with the reuse program?

Partners may vary by state, but some likely candidates include:

- Independent Living Centers
- Area Agencies on Aging
- Specific Health Groups (ALS, MDA, etc.)
- Veteran's Groups
- Hospice
- Civic organizations
- Healthcare facilities

Key Lessons Learned from Kansas

- Partner with existing groups to form a statewide network.
- Cultivate relationships with commercial DME providers.
- Optimize the use of time and resources for device donations.
  - Focus on the value of devices.
  - Specify what you need to be donated.
  - Identify likely sources of donations.
- Market the program.

How Reuse Value is Measured

Reuse programs save Medicaid money through shared services in some locations, and through the savings to customers versus the purchase of new devices. The table at right is for only 2017 for all devices, including Medicaid activities.

State	Devices	Value
Kansas	736	$748,0118
Oklahoma	1,671	$1,406,945
ALL States	**62,404**	**$25,633,760**

Center for Assistive Technology Act Data Assistance (CATADA). (2018). *Overall program summary report for FY 2016.* Retrieved 01/26/2018 from http://www.catada.info.

Measuring the Success of Reuse

Sara Sack, Director of the KEE Reuse Program, applies business metrics, specifically the use of simple ROI – return on investment analysis – to measure and communicate the value of the program.

$ Gain from investment

minus $ Cost of investment

= $Net gain

Divided by

$ Cost of investment

= ROI

Following the Kansas example:

Oklahoma

- Oklahoma Health Care Authority (Medicaid agency) was legislatively mandated to develop and implement a retrieval DME program.
- Medicaid DME program director attended 2009 National Reuse Conference.
- ABLE Tech responded to Request for Proposal (RFP) and was awarded contract.
- Oklahoma Durable Medical Equipment Reuse Program was funded December 2011, operational early 2012.
- Started in Oklahoma City, quickly became statewide.

South Dakota

- Originated with Medicaid Solutions Workgroup, November 2011
- Created a workgroup
- Collaborated with Pass It On Center for Indicators of Quality and lessons learned from other Medicaid partnerships
- Program launched in 2016, based in Sioux Falls, serves 50% of the state population now, with plans to go statewide.

Convenience of Backup Devices

Sometimes the best solution is a second device at work or at school to avoid potential strain in moving heavy devices, or for the convenience of assured availability and not transporting the device. Insurers do not pay for duplicate devices.

Reuse may be the solution in some cases.

How We Address Liability

- Identify and comply with applicable laws, statutes, and standards
- Adopt Indicators of Quality for AT Reuse
- Devise strategies, policies, and procedures to mitigate risk
- Train employees and volunteers
- Consider appropriate levels of insurance

What if reused AT qualifies as a “Medical Device”?

- Program must comply with regulations if the device requires a prescription (Policy, procedure)
- Program must be able to track the reassigned device for consumer warnings or device recalls (Client database, inventory system, policy and procedure)

Inform Consumers

- Disclose the risks of acquiring reutilized devices
- Clarify what warranties, if any, are offered with the devices
- Create and post a list of “best practices” for consumers acquiring reutilized devices (learn to use and clean devices appropriately).

Sanitize Devices Properly

Devices distributed by reutilization programs should be sanitized according to the manufacturers' specifications and CDC guidelines, either manually or with the use of automated cleaning equipment.

Use Qualified Technicians for Repair and Refurbishing

Repairs or adjustments to devices should made by a qualified technician.

Unless the manufacturer specifications indicate the technician must have a specific certification, a qualified technician is taken to mean someone with experience refurbishing that type of device, with proper skills and training to understand the manufacturer specifications and conduct the repairs.

Match Customer to Appropriate Device

- The reuse program should match the customer to a device appropriate for the need and that fits the customer.
- Train the customer in the proper operation of the device.
- Provide information about the proper ongoing sanitization of the device.

Loan or reassignment?

- The reuse program should have the customer sign a reassignment form transferring ownership, or
- The Medicaid program may retain ownership and treat the transfer as an open-ended loan.

The reassignment form should specify what, if any, warranty is provided with the device.

End of Life Recycling

If a program recycles parts in order to refurbish devices, it should be aware of and comply with its state's solid waste and e-waste laws and regulations when disposing of those parts that cannot be reutilized.

Values from different perspectives

- **Economic:** Monetary value of the investment and outputs, what was saved; return on investment of funds
  - Calculate the savings to the customers
  - Calculate return on investment for use of the funds
- **Environmental:** Measurable impact on resources used or recycled; avoided impact on the environment
  - Measure amount reused (tonnage saved from disposal x the disposal cost)
- **Societal:** Outcomes measurement
  - Individuals who could return to work or education with AT
  - Individuals who can continue to live independently with the aid of AT
  - The avoided healthcare costs when AT is available when needed

Contact the Presenters

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