Wisconsin State Senate
24th Senate District

Serving Wood, Portage, Adams,
Waushara, Monroe, and Jackson

PATRICK TESTIN
STATE SENATOR

DATE: January 8th, 2020

RE: Testimony on 2019 Senate Bill 605

TO: The Senate Committee on Health

FROM: Senator Patrick Testin

Thank you committee for hearing my testimony on Senate Bill 605 (SB 605). SB 605 isn't just a bill that modifies the definition of "complex rehabilitation technology" – it's a bill that enables people with severe physical disabilities to live better lives.

Standing may not seem remarkable for the majority of us, but that act has the ability to give disabled people a healthier, more independent life.

There is medical proof that standing can improve kidney function, cardio-pulmonary function, bladder and G.I. function for people who otherwise would be confined to a wheelchair or bed at all times. Standing also can reduce the presence of pressure sores and skin ulcerations which cause great discomfort and often result in surgeries costing Medicaid hundreds of thousands of dollars.

You will hear today from Medical professionals who can testify as to the medical benefits of standing technology. More importantly, you will hear from those who have used standing technology to revolutionize their lives.

Please join us in supporting SB 605, the Standing with Dignity bill.

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State of Wisconsin
Department of Health Services
Tony Evers, Governor
Andrea Palm, Secretary

TO: Members of the Senate Committee on Health Human Services

FROM: Lisa Olson, Legislative Director, Department of Health Services

DATE: January 8, 2020

RE: 2019 Senate Bill 605, relating to reimbursement under the Medical Assistance program for complex rehabilitation technology.

Good morning, Chairman Testin and members of the Senate Committee on Health and Human Services. My name is Lisa Olson and I am the Legislative Director at the Wisconsin Department of Health Services (DHS). I appreciate the opportunity to provide testimony for information only on Senate Bill (SB) 605, which would expand the definition of complex rehabilitation technology (CRT) in state statute and make changes to Medicaid's prior authorization process for these items.

Last session, 2017 Wisconsin Act 306 was enacted and required the Department to create standards for the supply and reimbursement of CRT within the Medicaid program. CRT was defined to include items such as power wheelchairs, adaptive seating and positioning items, as well as accessories related to any of these items.

SB 605 adds power seat elevation and power standing components of power wheelchairs to the existing definition of CRT. DHS recognizes the importance of standing technology for individuals with significant physical impairment or functional limitations and we support this provision. We want to ensure that individuals have the equipment they need to remain healthy and prevent further illness or injury.

In addition to expanding the definition of CRT in state statute, SB 605 also proposes removing Departmental oversight of medical necessity determinations within complex rehabilitation technology items, or services for complex needs patients.

Currently, CRT is covered by Medicaid with prior authorization (PA). As part of this prior authorization process, the Department employs an occupational therapist consultant and physical therapist consultant with expertise on CRT to ensure that equipment and services being requested are medically necessary.

Generally, prior authorization is designed to safeguard against unnecessary or inappropriate care and services, avoid covering an item that Medicare has either already paid for or already denied because it was not medically necessary, and assess the quality and timeliness of services. Because CRT items can be expensive, it is important that the Department has an oversight role prior to approving requests spending taxpayer dollars.

Prior authorization requests received by DHS are required to be completed within 20 working days after being received. Additionally, in emergency situations, the PA requirement may be waived.

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We are currently implementing 2017 Act 306 and as part of that process, have convened an advisory committee comprised of advocates, CRT manufacturers, and others. We are happy to work with them as well as providers to, if needed, better outline clear approval criteria for CRT items and services.

DHS supports covering different types of complex rehabilitation technology under the Medicaid program, however, we note that as written, SB 605 would create approval authority for CRT that is separate and unique from other Medicaid services that are covered via prior authorization.

Thank you for your time, and I am happy to take any questions.

Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

Senate Bill 605
Senate Committee on Health & Human Services
January 8, 2020

Chairman Testin, members of the Committee, thank you for the opportunity to testify today. My name is Tim Lundquist and I am the Director of Government and Public Affairs at the Wisconsin Association of Health Plans. The Association is the voice of 12 Wisconsin community-based health plans that provide employers and individuals across Wisconsin access to high-quality health care. Many of these health plans partner with the state through Medicaid Managed Care, where they collectively serve 220,000 individuals in Wisconsin's Medicaid programs, including SSI and Family Care.

The Wisconsin Association of Health Plans opposes Senate Bill 605 because it eliminates a widely-accepted process that ensures appropriate patient care, manages the State's Medicaid costs, and guards against waste, fraud, and abuse.

Medicaid health plans today follow a process outlined in state law to evaluate the medical necessity of requested complex rehabilitation technology (CRT) devices and services. In that process, health plan medical experts review whether a requested device or service is required to prevent, identify, or treat a recipient's illness, injury or disability, and meets standards related to patient safety, quality of care, and cost-effectiveness.

This process leverages the expertise of a diverse group of experienced clinicians to ensure objective, evidence-based standards are used to evaluate CRT requests. It also ensures Medicaid pays for services and equipment that are medically necessary and likely to improve health outcomes, as opposed to items solely of convenience or individual preference. Today, Medicaid enrollees who are not satisfied with a health plan's CRT coverage determination have a number of opportunities for appeal, including the grievance process and a hearing before an administrative law judge.

Section 2 of SB 605 nullifies a long-standing, expert review process by granting a single physician the ability to determine the medical necessity of CRT devices and services. Eliminating the opportunity for outside, objective clinician input will allow for a more subjective application of "medical necessity" for CRT, leading to less effective delivery of services and equipment and increased program costs. It also increases the likelihood of waste, fraud, and abuse because no outside entity will review a physician's determination of medical necessity.

For these reasons, community-based health plans respectfully request committee members oppose this legislation. I would be happy to answer any questions you may have.

Testimony Presented to
Senate Committee on Health and Human Services
In opposition to Senate Bill 605 and AB 660

Presented by Dr. Michele Bauer
Chief Medical Officer,
Group Health Cooperative of Eau Claire
January 8, 2020

Thank you Chairperson Testin and members of the Committee for the opportunity to provide testimony in opposition to SB 605 and AB 660. My name is Michele Bauer. I am the Chief Medical Officer of Group Health Cooperative of Eau Claire.

By way of background, Group Health Cooperative of Eau Claire is a non-profit cooperative that provides health insurance coverage to 60,000 residents of Western Wisconsin through both commercial and government coverage. We are a member-governed plan, meaning our board of directors is comprised completely of consumer members covered by Group Health Cooperative. I have been the chief medical officer for 9 years. Prior to that, I was a practicing physician with Marshfield Clinic for 20 years, and during that time an assistant medical director for Security Health Plan for ten years. I am board certified in internal medicine.

There is no dispute that rehabilitation technology and adaptive or assistive devices are extremely important for individuals in need of assistance with activities of daily living. The question is how to best provide those services, and how to do so in a responsible manner.

Background of the Review Process

As a health plan, we regularly receive requests for medical equipment, and I think it is helpful to understand the process of how these requests are reviewed.

The first step is for a physician to write an order for a wheelchair and other equipment. This request is usually given to a medical equipment company that will evaluate the patient's needs. After the evaluation, the medical equipment company rewrites the order to include all of the items that will be dispensed. This order then goes back to the physician who signs off on it.

At this point, we would receive the request to be reviewed to ensure evidence-based clinical practice guidelines are being followed. If all of the appropriate information is

provided with the request, this review takes less than 48 hours. Quite often, supporting information or documentation is not provided, and follow-up requests are necessary.

If the optional features on the wheelchair are not warranted, based on evidence based practice guidelines, the request will be partially approved, and the physician or medical equipment company is given the opportunity to provide further documentation to justify the additional features. This step is usually what slows the process down, and can go quickly or slowly based on the ability and willingness of the company to provide the needed information.

In my 20 years as a practicing physician, and in my experience as a chief medical officer, I can say it is common for requests to be made that do not follow accepted clinical treatment protocols. There has been significant research to support this concern. Comprehensive national studies have documented that patients receive medically appropriate care only slightly more than half the time.

Throughout this process, patients or physicians have the ability to appeal any determination. For enrollees in the Medicaid program, this right for enrollees includes the ability to request a fair hearing review with an administrative law judge.

Issues Created by Eliminating Medical Necessity Review

SB 605/AB 660 would remove the ability for the Medicaid program to review, based on medical necessity, requests for wheelchairs and other assistive equipment, and rely solely on the word of the ordering physician. This eliminates any ability to consider whether the equipment is being provided based on generally accepted clinical practice guidelines.

On its surface, this would seem to streamline a process that to some might seem bureaucratic. I can understand that.

However, the process is detailed for a reason. As I have outlined, the determination of what components to include in a wheelchair are usually not made by the physician, but rather by the medical equipment company. Fraud, waste and abuse (FWA) related to wheelchairs and similar equipment is a major concern in the Medicare program nationally. Medical equipment is one of the largest areas of FWA in Medicare and Medicaid.

This bill would invariably aggravate the problem in the WI Medicaid Program. The only thing a medical equipment manufacturer would need to add unnecessary equipment to a wheelchair would be a WI licensed physician to say it is necessary. That physician could be living anywhere, and is not required to examine the patient. Abuse of the program would be inevitable as less than scrupulous players would be attracted to Wisconsin's "open market". In addition, with no accountability, current providers would be less and less diligent about controlling cost.

The proposed change creates another subtle, but alarming situation.

As I said, FWA in this type of care of already well documented. By removing any oversight, and codifying a standard that "medically necessary" is determined by any physician, the Legislature would be making it significantly more difficult for the State to identify and stop abusers. There would no longer be any accepted guideline that would delineate appropriate from fraudulent.

In other words, the legislation not only makes it easier for fraud, waste, and abuse to occur, but it also makes it much more difficult for the State to stop it or prosecute it even when they know it is happening. In the end, the increased expense of unnecessary services would potentially weaken the State's financial ability to provide appropriate care and services. I don't believe that is what legislators intended by drafting this language.

Conclusion

We fully agree that all patients should receive medical care appropriate to their need. We work diligently to ensure that happens. We fully agree with the sentiment of the proposed legislation, but believe it will do more harm than good. Under the current processes, everyone's interests are balanced, and patients are protected.

Thank you again for the opportunity to offer my perspective. I'd be happy to answer any questions. If you have additional questions, please do not hesitate to contact me at 715-852-5721, or mbauer@group-health.com.

Providing quality coverage to nearly 3 million Medicaid and private sector enrollees in Wisconsin.

To:	Members, Senate Committee on Health and Human Services
From:	R.J. Pirlot, Executive Director
Date:	January 8, 2020
Re:	Please oppose Senate Bill 605

The Alliance of Health Insurers (AHI) is a nonprofit state advocacy organization created to preserve and improve upon consumer access to affordable health insurance in Wisconsin, both via the private sector and public programs. Our members provide managed care to approximately 65 percent of the participants in Wisconsin's Medical Assistance program (including both BadgerCare and SSI program participants). AHI members are dedicated to delivering affordable, high-value care to the state's Medicaid population.

AHI members are contractually required to provide enhanced care management to the state's SSI Medicaid population. In order to assist Wisconsin's good stewardship of taxpayer dollars appropriated to Medical Assistance, foundational elements of Wisconsin's Medicaid managed care program include ensuring the level of care is appropriate, accessible, and cost-effective. Currently under the state's Medical Assistance programs (including SSI-Medicaid and Family Care), complex rehabilitation technology (CRT) is a covered service with prior authorization. As a part of the prior authorization review, the CRT is evaluated for appropriateness based on criteria, medical necessity as defined by § DHS 101.03(96m) of the administrative code, and benefit coverage.

SB 605 seeks to undo the current medically necessary determination process <u>for one Medicaid service category</u> (CRT). Instead of following a medically necessary review process that is in accordance with state and federal Medicaid policy, this legislation designates the decision of whether a specific CRT item is medically necessary and cost-effective compared to an alternative medically necessary item, and should be paid for by taxpayers, *solely to* a member's physician. This removes the managed care organization or the Department of Health Services from the determination.

Based on our review, *no other* covered service or item is carved out from the medically necessary review. Numerous specialized DME items, for example prosthetics, orthoses, and oxygen therapy equipment, require prior authorization, including the medical necessary review. Exempting CRT from this uniform policy raises the issue of what benefits and for what reasons should a carve out even be considered. This policy change could lead, we fear, the state down the path of paying for Medicaid services without adequate safeguards against excess payments, inappropriate care, and poor quality care.

One claim for the need for change in SB 605 is that there are significant delays in the approval process, leaving patients waiting for CRT and vulnerable to developing additional avoidable medical conditions. However, this anecdotal claims are not aligned with current prior authorization timelines in the administrative code, of which the MCOs and DHS are required to follow. Under § DHS 107.02(3)(a) of the administrative code, 95 percent of prior authorization

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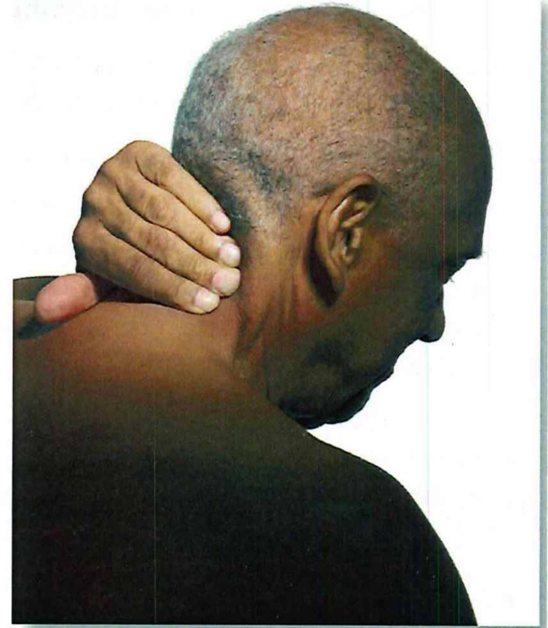
requests, including the medical necessity determination, must be acted upon within 10 working days and 100 percent of prior authorization requests within 20 working days, once all the information necessary to make a the determination is submitted to DHS or the MCO.

In addition, under managed care, DHS pays the MCOs pre-set capitation payments and in exchange for these pre-set payments, MCOs assume the full cost of care for members enrolled in the plan. Because the capitation payments are pre-set, if costlier services are utilized or if appropriate services are not provided in a timely fashion and additional care is needed, the additional expense is assumed by the MCOs. Therefore, contracted Medicaid managed care organizations are incentivized to keep members healthy and ensure appropriate care benefits are efficiently and timely delivered.

Finally, last session, 2017 Wisconsin Act 306 was signed into law and which established Complex Rehabilitation Technology as a separate benefit under the state's Medicaid program and which directed the Department of Health Services to promulgate rules regarding CRT under Medicaid. In October 2019, DHS released a draft rule for comment. The current draft rule (which recently closed for public comment) includes a comprehensive prior authorization review process to accurately determine if the CRT is medically necessary, including a clinical review and assessment. SB 605 seeks to circumvent the rulemaking process and eliminate a review of whether a specific CRT service or device is medically necessary and should be paid for by taxpayers.

We ask the committee to reconsider the precedent established under this bill, and the potential fiscal effect it will have on the limited resources of the state's Medicaid program. For these reasons, we request you oppose this legislation. Thank you for your consideration of this request.

Occupational Therapy and **Pain Rehabilitation**



Chronic pain is a major public health problem in the United States. One in four Americans, or 116 million people, have some form of persistent pain. Chronic pain causes tremendous human suffering for its victims, their families, and society as a whole. The Institute of Medicine's report (National Academies Press, 2011) estimated that costs of providing medical care and lost productivity due to pain are $560 to $625 billion annually. This dollar amount exceeded the combined costs of heart disease, diabetes, and cancer.

Chronic pain can lead to increased dependency on others, loss of worker and family roles, and difficulty participating in everyday activities. Sleep problems, depression, anxiety, social isolation, and overall reduced quality of life are common issues facing people with chronic pain. The pain is often intractable, and resistant to or not relieved by available medical approaches. A biopsychosocial, interdisciplinary approach has the greatest evidence base for efficacy, cost effectiveness, and preventing iatrogenic complications (Schatman, 2012).

Role of Occupational Therapy

Over time, chronic pain leads to a sense of disempowerment, and the loss of control to engage in daily activities. Using a self-management approach, occupational therapy focuses on helping individuals participate in daily activities in adaptive ways. Through the occupational therapy process, specific performance problems in daily living are assessed, valued activities are identified, and evidence-based therapeutic approaches are used to address the client's goals. Occupational therapy is a necessary and core component of any comprehensive pain rehabilitation program.

Intervention Approaches

Education

Clients are often uninformed about the neurophysiology of the pain response, their specific pain diagnosis, and non-medical approaches used to manage pain. The process of informing clients about their pain, and clarifying treatment expectations and the self-management approach, prepares them for active participation in the rehabilitation process.

Functional Goal Setting

Clients are involved in identifying and setting goals for their own therapy. This process supports client motivation and participation while improving therapy outcomes.

Training

- Proactive Pain Control: Clients are taught to independently and proactively use pain control modalities, such as heat or cold. When used safely and proactively (vs. reactively), increases in baseline pain levels can be avoided throughout the day, enabling participation in daily activities.
- Safe Body Mechanics and Ergonomics: Clients often become fearful of pain with movement and subsequently avoid activities. Instruction in safe body mechanics, with opportunities to practice and receive feedback, promotes feelings of self-efficacy. Clients learn to safely perform basic activities of daily living, work, leisure, social, and community activities using techniques that reduce or prevent strain on body structures. Ergonomic assessments identify environmental factors that may be contributing to pain problems and that can be modified to improve function.

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- Neuromuscular Re-education: Over time, persistent pain leads to abnormal movement patterns and postural deviations. Occupational therapists retrain clients to perform tasks with the appropriate muscle groups using adjunctive modalities, such as electromyographic biofeedback, to prepare them to participate in valued activities.
- Muscle Tension Reduction Training: Pain is a stressor on the body and mind. Learning to relax muscles and calm the mind allows the client to feel in control of his or her body while reducing pain levels.
- Communication Skills Training: Chronic pain is an invisible disability. Assertive behavior (e.g., saying "no," explaining needs and desires comfortably) enables clients to manage their disability with less conflict and frustration.
- Proactive Problem Solving: Previously avoided activities may be accomplished when clients are taught to be proactive problem solvers. This process involves anticipating potential problems and planning for challenges ahead of time.
- Pacing Activities: Many clients with chronic pain have problems in self-regulating their activity levels. This often leads to flare ups whereby they experience higher than baseline levels of pain, for extended periods. Occupational therapists teach clients to pace their activities, such as taking breaks, changing the way an activity is done, or asking for help, as effective coping strategies.

Home Exercise Program
Self-management includes actively maintaining a healthy lifestyle, including home exercise programs. These programs are specifically tailored to meet the needs of individual clients and include physical movement, daily relaxation or meditation practice, proactive use of pain control modalities, etc.

Screening for Additional Referrals
Chronic pain can be accompanied by psychological, cognitive, emotional, and/or physical difficulties. When appropriate, therapists may refer clients for additional services to facilitate best practice and optimal therapy outcomes.

How and Where to Refer a Patient for Occupational Therapy Services

Occupational therapy to address chronic pain is best provided by therapists skilled in pain management and as part of an interdisciplinary team. Comprehensive pain management programs can be found in outpatient centers, although there are a few inpatient programs available in the United States. Additionally, occupational therapists may provide pain management services as part of palliative or hospice care or home health services. Early referral for services leads to better outcomes (i.e., before the pain leads to increasing levels of physical deconditioning, psychological distress, and overutilization of health care).

Conclusion

When pain becomes chronic, it leads to pain-related disability, human suffering, and tremendous economic costs. Evidence-based practice supports interdisciplinary and biopsychosocial approaches as the gold standard for managing chronic pain. Occupational therapy, focused on client-centered care and promoting optimal independence and satisfaction with performance, is an essential part of any comprehensive pain management program.

References

National Academies Press. (2011). *Relieving pain in America.* Washington, DC: Author.

Schatman, M. (2012). Interdisciplinary chronic pain management: International perspectives. *IASP Clinical Updates, 20*(7), 1–5.

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