



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

August 5, 2016

The Honorable Ron Wyden  
Ranking Member  
c/o Leigh Stuckhardt  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, D.C. 20510

**Re: Support and Additional Proposals for the Medicare Affordability and Enrollment Act of 2016**

Dear Leigh:

The Co-chairs of the Consortium for Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the Senate Finance Committee's draft *Medicare Affordability and Enrollment Act of 2016*, recently circulated legislation to make improvements to the Medicare benefit related primarily to affordability and enrollment. The CCD is a coalition of more than 100 national disability organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

We applaud you and your colleagues on the Finance Committee for your efforts to address cost and eligibility within the Medicare program, and we support the bill's overarching goals. In particular, we wish to highlight our strong support for two of the bill's provisions:

1. Protecting Against High Out-Of-Pocket Expenditures for Medicare Fee For Service Beneficiaries: As of 2015, half of all Medicare beneficiaries had incomes of less than \$24,150, while a separate Kaiser Family Foundation [report](#) found that as of 2011, Medicare beneficiaries spent an average of \$5,368 in out-of-pocket costs on health care, including premiums for Medicare, supplemental insurance, and other related costs. That same report indicated that out-of-pocket spending has grown by 2.3% on average per year<sup>1</sup>. The draft bill appears to address this issue with its out-of-pocket cost sharing caps. A [recent report](#) from the Kaiser Family Foundation modeling various options to modify Medicare's benefit design, including testing various cost-sharing caps at varying amounts

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<sup>1</sup> Beneficiaries' out-of-pocket spending on medical and long-term care services increased at an average annual rate of 2.3% between 2000 and 2011, per Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2000-2011 Cost and Use files.

and with other provisional policies, produced mixed results in terms of impact on assistance to beneficiaries and overall federal spending. As the report concludes, “adding a cost-sharing limit would provide valuable financial protection to a relatively small share of the Medicare population that incurs catastrophic expenses in any given year, although a larger share of beneficiaries would be helped by this provision over multiple years.” The draft bill’s cost-sharing cap is open for discussion, with its current amount denoted with brackets, indicating the committee’s interest in gauging the right amount.

2. Elimination of the 24-month Waiting Period for Medicare Coverage: This proposal has been a long-standing goal of the disability community and we continue to strongly support elimination of the 24-month waiting period for individuals with disabilities who qualify for Social Security Disability Insurance (SSDI). These provisions would permit individuals who are no longer able to work due to disability to obtain the necessary medical services they need on a timely basis. This, in turn, will help such individuals remain as healthy, functional and independent as possible, thereby lessening Medicare expenditures over the long term.
3. Streamlining Medicare Eligibility: The bill contains a number of provisions that would streamline, coordinate and align enrollment procedures as well as provide additional funding for low income Medicare beneficiaries. These program improvements are important for seniors and people with disabilities and CCD supports these provisions.

While we recognize that the emphasis of this bill is focused on streamlining eligibility and addressing affordability within the Medicare program, we would like to take this opportunity to request serious consideration of additional Medicare provisions that would ask for the inclusion of several similar provisions focused on improving the Medicare program and access to its services and programs. Specifically, CCD encourages the Committee to:

1. **Eliminate the Medicare Outpatient Therapy Caps**: The annual cap on the dollar amount of outpatient therapy services is a crude and arbitrary tool used by the Medicare program to limit the amount of clinically appropriate covered services that a beneficiary can receive. Unfortunately, this cap on coverage effectively discriminates against the patients who need outpatient therapy the most, and limits the ability of providers to offer clinically appropriate services to those patients. Despite Congress’s actions to implement a temporary exceptions process, a permanent legislative fix is needed to provide patients with access to the timely and appropriate care they need. We ask the Committee to strongly consider addressing this issue in its proposed legislation to ensure beneficiaries can access clinically appropriate, covered services in the future that meet their needs.
2. **Treat Complex Rehabilitative Technology (CRT) Separately from Durable Medical Equipment (DME)**: Complex rehabilitation technologies (CRT) are medically necessary, individually configured products such as certain types of manual and power wheelchairs, adaptive seating systems and alternative positioning systems that keep people with significant disabilities healthy, functional, and independent. CRT is required by a small subset of Medicare beneficiaries with mobility impairments, including individuals with Amyotrophic Lateral Sclerosis (ALS), spinal cord injury, multiple

sclerosis (MS) and muscular dystrophy. CRT accounts for less than ten percent of Medicare’s wheelchair expenditures. For this small population with such advanced disability, these products cannot be utilized and are not beneficial unless they have essential components—coined “accessories”—such as head support systems, specialized seat cushions, sip and puff interfaces or tilt-and-recline features. For example, an individual with progressed multiple sclerosis who has lost feeling and function below the neck literally could not operate/move a CRT chair unless s/he has a head control interface. Similarly, that same individual could not safely remain in the chair without a trunk support system and would experience painful and costly pressure sores without a specialized seat cushion and a tilt-and-recline feature.

In 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPAA) and in doing so, specifically exempted complex power wheelchairs and accessories from Medicare’s Competitive Bidding Program. Congressional language in 2008 was limited to CRT power wheelchairs and accessories (and did not reference manual wheelchairs) since only power wheelchairs were included in Competitive Bidding at that time. Congress’s rationale for exempting these products was that individually configured CRT is used by a very small percentage of the population—but quite a vulnerable population whose access should not be disrupted. CRT is not suitable for inclusion in Competitive Bidding.

In late 2014, the Centers for Medicare and Medicare Services (CMS) announced that it planned to apply Competitive Bidding pricing to Complex Rehab accessories starting January 1, 2016. Fortunately, hearing consumers’ severe concerns about how Competitive Bidding pricing would negatively impact access to CRT accessories, Congress enacted a one-year delay—prohibiting CMS from applying Competitive Bidding pricing to power wheelchair accessories through December 31, 2016.

The disability community is grateful for this delay but urges the Committee to include a permanent solution in its draft legislation, such as the language contained in S. 2196/H.R. 3229, in order to ensure that patients can access the accessories and devices they need. From the consumer perspective, it is essential that both CRT power and manual accessories are exempted from Competitive Bidding. Once this exemption is firmly in place, CCD also supports the separation of CRT from the durable medical equipment (DME) benefit under the Medicare program in order to facilitate specific rules that are more appropriate to those with permanent, severe disabilities than those who need wheelchairs or other mobility devices post-surgery or on a short-term basis.

- 3. Establish Coverage of Seat Elevation Technology in Wheelchairs:** Under current policy, Medicare, through determinations made solely by its durable medical equipment (“DME”) contractors, does not cover seat elevation within powered wheelchairs. The stated reason for this lack of coverage is that seat elevation does not fit within the DME benefit category because it is “not primarily used to serve a medical purpose,” one of the required prongs of the DME definition. As a result, Medicare beneficiaries with mobility disabilities do not have access to this critical technology. Seat elevation is an accessory to a power wheelchair that is integral to its function for a person who needs to be able to

adjust his or her vertical seat position in order to achieve the full therapeutic benefit of a power wheelchair (i.e., DME). Seat elevation supports motion in a body part (i.e., the entire body) that enables and facilitates the individual's ability to independently transfer and reach – essentially allowing individuals with mobility disabilities, such as spinal cord injuries, to accomplish Mobility Related Activities of Daily Living (MRADLs). CCD respectfully requests the Finance Committee to explicitly define seat elevation technology as DME, thereby establishing coverage of seat elevation when embedded in a power wheelchair or other mobility device.

- 4. Pass S. 829, the Medicare Orthotics and Prosthetics Improvement Act of 2015:** CCD urges the Finance Committee to support S. 829, *The Medicare Orthotics and Prosthetics Improvement Act of 2015*, introduced by Sen. Grassley (R-IA) and Sen. Warner (D-VA). This bipartisan legislation is focused on reducing fraud, ensuring quality for patients in need of custom orthoses and prostheses, and saving taxpayer dollars. In addition, the legislation would assure patients the highest quality of care and eliminate suppliers with little or no education and training in the provision of custom orthotic and prosthetic care. Finally, the bill recognizes the value of the orthotist's or prosthetist's clinical notes as part of the patient's the medical record for purposes of determining medical necessity. We urge the Committee to support this bill to benefit Medicare beneficiaries with limb loss and orthopedic impairments.
- 5. Establish Coverage of Eyeglasses, Hearing Aids, and Dental Care to Modernize the Benefit Package:** We encourage the Committee to consider including language designed to strengthen the benefit package that Medicare beneficiaries receive by expanding coverage to include dental, vision, and hearing care. Recently introduced legislation in the House, H.R. 5396, the *Medicare Dental, Vision, and Hearing Benefit Act of 2016*, would do just that. That bill includes provisions that would repeal statutory exclusions preventing the coverage of dental, vision, and hearing services within Medicare, and extend coverage to items including dentures, eyeglasses, contact lenses, low vision devices, and hearing aids over time. CCD believes such language would strengthen the Medicare program, providing beneficiaries with important benefits they currently lack.

As you continue to develop the *Medicare Affordability and Enrollment Act of 2016*, we encourage the Committee to reach out to us if we can be of further assistance. We thank you for the opportunity to comment on this draft legislation and look forward to seeing the final legislative proposal.

Sincerely,

The CCD Health Task Force Co-Chairs

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